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**The Development of Medical Services in the Highlands and Islands of Scotland, 1843-1936**

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**UNIVERSITY OF DUNDEE  
SCHOOL OF HUMANITIES**

**SEPTEMBER 2013**

**THE DEVELOPMENT OF MEDICAL SERVICES IN THE  
HIGHLANDS AND ISLANDS OF SCOTLAND, 1843-1936**

**PATRICIA E. WHATLEY**

Thesis submitted in fulfilment of the requirements of the  
University of Dundee for the degree of Doctor of Philosophy

## **ABSTRACT**

This thesis charts the development of medical services in the Highlands and Islands of Scotland from the establishment of the new Poor Law in 1843 to the inception and development of the Highlands and Islands Medical Service from 1913 to 1936.

It begins with a brief survey of the topographical, social and economic conditions of the Highlands from 1845. It was within that context that the administrative structures that constituted Highland medical services were situated. They are traced in detail as is the interdependence which developed between local authorities, poor law administrative structures and, later, public health authorities, within the political context of the gradual extension of the authority of the state, enlightened medical thought, land reform and 'new liberalism'. It is argued that those factors, together with the longer-standing perception of the Highlands as an area requiring special attention, culminated in the establishment of the Highlands and Islands Medical Service enquiry, known as the Dewar enquiry. Established in 1912 it investigated the level and adequacy of medical services in the region. It recommended the establishment of a central body to improve the provision of medical services for the majority of the population and it also highlighted a need for a greater number of fully-trained nurses. The Dewar enquiry's methodology is documented and its findings assessed and evaluated. The development of district nursing is examined in a separate chapter to avoid duplication and to facilitate its specific features to be highlighted.

The recommendations of the Dewar enquiry resulted in the establishment in 1913 of the Highlands and Islands Medical Service, which provided the first State-funded medical care for the Highland non-pauper population and also aimed to improve the conditions of medical practitioners working there. It is widely described, uncritically, as a 'forerunner of the National Health Service'. Existing secondary literature on it is generally superficial, largely uncritical and relies primarily on published annual reports. One of the aims of this study has been to use new primary sources to investigate in detail its structure, administration and policy development and to provide a more balanced analysis of its development and impact.

This study challenges the veracity of the view that it was an unqualified success and demonstrates that while it was unique, innovative and did achieve improvements in many areas of medical and nursing service, by 1936, there were still accepted

weaknesses in the provision of medical and nursing services. Furthermore, integral to the Service were many of the tenets of self-help and philanthropy; voluntary contributions from all individuals and bodies related to it were embedded into its policies and administration, closely monitored by the Treasury. Following Cameron and Hunter's work on land reform this thesis makes a contribution to historical understanding of the development of public policy in the Highlands, within a medical context, during the second half of the nineteenth and early decades of the twentieth century. The period of study ends in 1936, the date of the Cathcart Report, which reviewed the state of Scottish health services.

The principal achievement of this thesis is to present a fuller and more accurate understanding of the complexity of the nature and development of medical services in the Highlands, with particular emphasis placed on the Highlands and Islands Medical Service. Widely held perceptions of it have been moderated while its importance has been demonstrated, not as a forerunner of the National Health Service, but as a striking example of the modification of the Victorian self-help ethic within the context of a publicly-funded subsidised service for a particularly vulnerable section of society. A major conclusion is that many of the problems inherent in the Highlands and Islands, related to geography, isolation and weather, which were insurmountable in the nineteenth and early twentieth centuries, still exist today and present a greater indomitable force than any level of medical service can mitigate against.

## ACKNOWLEDGEMENTS

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I could not have done this without the continuing support of my family, they deserve special thanks, especially my husband, Chris, who has lived with this for some time with great patience, and my children Christopher and Nicola.

## **DECLARATION**

I declare that I am the author of this thesis, that unless otherwise stated, I have consulted all references cited. The work of which this thesis is a record has been carried out by me and has not previously been accepted for a higher degree.

Patricia Whatley  
September 2013

## TABLE OF CONTENTS

Abstract	ii
Acknowledgements	iv
Author declaration	v
Table of Contents	vi
List of Tables	viii
List of Photographs	xi
List of Abbreviations	xiii
<b>Introduction</b>	<b>1</b>
<b>Chapter 1: Topography, economy and society: the context for medical provision in the highlands</b>	<b>18</b>
<b>Chapter 2: The foundations of medical provision in the Highlands and Islands, 1843-1880</b>	<b>31</b>
2.1 The Old Scottish Poor Law: pressure for change	
2.2 The Poor Law Enquiry 1843-45	
2.3 Population and location: factors hindering change	
2.4 The Medical Relief Grant 1848	
2.5 The Physicians Enquiry and Report 1850-1852	
<b>Chapter 3: The modernisation of medical provision in the Highlands and Islands: towards the Dewar Commission, 1880-1912</b>	<b>51</b>
3.1 The extension of the Medical Relief Grant	
3.2 Public health service: policy and ideology	
3.3 The establishment of county government	
3.4 Conditions of employment in Highland districts:6	
I. Qualifications and professional development	
II. Salaries and lifestyle	
III. Security of tenure, pensions and lack of holidays	
IV. Housing	
V. Private practice and the Poor Law	
<b>Chapter 4: The background to the establishment of the Dewar enquiry</b>	<b>91</b>
4.1 The Highlands and Islands as a special area	
4.2 Social and economic conditions and the impact of poor medical services	
4.3 Political factors	
<b>Chapter 5: The Dewar enquiry and report</b>	<b>115</b>
5.1 The infrastructure and methodology of the Dewar enquiry	
5.2 The findings of the Committee: the state of medical services in 1912	
5.3 The conclusions and recommendations of the enquiry	
5.4 The importance of the Dewar enquiry: analysis and evaluation	

<b>Chapter 6: The early administration of the Highlands and Islands Medical Service</b>	<b>153</b>
6.1 The calculation of the HIMS Grant, 1912	
6.2 The structure of the proposed HIMS and early organisation	
6.3 The establishment of the HIMS Board and area of remit	
6.4 Early preparations for the allocation of the Fund	
<b>Chapter 7: ‘A Charter For Emancipation’?: The Development of the Highlands and Islands Medical Service 1915-1936</b>	<b>179</b>
7.1 Approval and implementation of the HIMS schemes 1915-18	
7.2 The transfer of the HIMS to the SBH, 1919- 1929	
7.3 The transfer of the HIMS to the DHS, 1929-36	
<b>Chapter 8: The role of nursing in the Highlands and Islands Medical Service</b>	<b>215</b>
8.1 The Historical And Historiographical Background	
8.2 1890-1912: Handywomen to Jubilee nurses	
8.3 1912-1919: The Dewar enquiry and the impact of war	
8.4 1919-1936: Growth and Consolidation	
<b>Conclusion</b>	<b>247</b>
<b>Bibliography</b>	<b>255</b>
<b>Appendices</b>	<b>271</b>
<b>Photographs</b>	<b>307</b>



## LIST OF TABLES

Table 1.1	Location of new telegraph offices 1897-1902
Table 1.2	Numbers of Houses in Harris where the cattle were housed in the dwelling
Table 1.3	Steamer imports to Lewis 1884
Table 2.1	Scottish Counties with number of persons greater than 60 per 1000 of population in 1901
Table 2.2	Scheme for distribution of the Medical Relief Grant, 1848
Table 2.3	Actual expenditure upon medical relief in 1847, minimum expenditure to entitle participation in Medical Relief Grant and share of grant apportioned to each large Highland parish
Table 2.4	Actual Expenditure on Medical Relief in 1847, Minimum Expenditure to entitle participation in Medical Relief Grant and Share of Grant Apportioned to each of the Parishes of Sutherland
Table 2.5	Numbers of parishes with/without Medical Officers in Highland parishes, 1880
Table 3.1	Expenditure on Medical Relief in Scotland 1846-1902
Table 3.2	Highland parishes requiring the parochial medical officer to provide medicines from their salary and those with a fixed sum in addition to their salary
Table 3.3	Expenditure on trained sick nursing in Scotland, 1885-1911
Table 3.4	Sum expended on medical relief (MR), per head of population and cost per pauper in a selection of Lowland counties and in the Highland counties in 1847 and 1902
Table 3.5	Expenditure on Medical Relief in The Lews in 1896 and 1905
Table 3.6	Turn-over (%) of general practitioners, in Orkney, Sutherland, and Selkirkshire and Haddington, 1900-1930
Table 3.7	Number of doctors and the number with higher qualifications in Orkney, Sutherland, and Selkirkshire and Haddington, 1900, 1905, 1910
Table 3.8	Salaries of Caithness Medical Officers' in 1902

Table 3.9	Return of Medical Officers dismissed by Parish Councils since 15th May, 1895
Table 3.10	Return of Parishes in Highland Counties in which the Office of Resident Parochial Medical Officer was Vacant in the last Seven Years, 1903, stating (a) Name of Parish (b) Number of Times a Vacancy has Occurred (c) Length of Time Office has been Vacant in each case
Table 5.1	Mileage for travel costs, 1912
Table 5.2	Number of days, date and location of the meetings carried out by the Dewar Committee, 15 August – 1 November 1912
Table 5.3	Native Gaelic speakers in Highland counties, 1881 and 1911
Table 5.4	Variations in doctors' public salaries in the parishes of Orkney County
Table 5.5	Numbers of doctors in Orkney, Sutherland, East Lothian and Selkirkshire with higher qualifications, 1910-1910
Table 5.6	Proportion of uncertified deaths in Highland Counties, 1909 and 1910
Table 5.7	Percentage of uncertified deaths in parishes of Sutherland
Table 5.8	Deaths registered in 11 Skye registration districts 'for past five years' to 31st December 1911
Table 5.9	Age of death and number of uncertified deaths, Lochs, Barvas, Uig and Stornoway landward, 1911
Table 5.10	List of General Hospitals in the Highlands and Islands, 1912
Table 6.1	Incomes of doctors practising in the Highlands, 1913
Table 6.2	Total Medical Subvention Required
Table 6.3	Estimated Amount Required for Dewar Recommendations
Table 6.4	Proposals received in response to Circular Letter from Highland Counties. Total Estimated Funding Required
Table 6.5	Suggested Requirements for the County of Shetland
Table 6.6	Amounts Paid to each Insurance Committee, 1913 & 1914
Table 6.7	Finances of the Board, 31 December 1914

Table 7.1	Numbers of doctors with arrangements with the HIMS Board to give attendance at modified fees in 1919
Table 7.2	Balance of Fund at 31 Dec 1916-19
Table 7.3	Pre-War and 1920 estimates for capital expenditure
Table 8.1	The Increase of Nursing Associations in the Highlands, 1890-1897
Table 8.2	Govan trained 'Cottage' Nurses sent to work in the Highlands, 1905-1912
Table 8.3	Location of Queen's Nurses in the Highlands in 1900
Table 8.4	Number of Nurses Trained Annually at Queen Victoria's Jubilee Nursing Institute, 1889-1921
Table 8.5	Numbers of nursing associations and nurses subsidised by the Medical Service Board, 1914
Table 8.6	Numbers of Highland districts with Queen's nurses in 1900 and 1912
Table 8.7	Income of the Sutherland Nursing Association, 1911
Table 8.8	Hebridean Islands with no doctor and a resident nurse, 1931

## LIST OF PHOTOGRAPHS

Plate 1	Shetland nurse on bike, <i>c.</i> 1930s.
Plate 2	Shetland nurse on motorbike, <i>c.</i> 1930s.
Plate 3	The Dewar Committee, 1912.
Plate 4	John A. Dewar, Lord Provost of Perth.
Plate 5	Murdoch Beaton, Secretary, Dewar Enquiry.
Plate 6	Highlands and Islands Medical Services Committee tour, October, 1912.
Plate 7	Highlands and Islands Medical Services Committee tour, 1912.
Plate 8	Doctor H.P. Taylor and car, Yell, Shetland, <i>c.</i> 1913.
Plate 9	Opening of Gilbert Bain Hospital, Lerwick, 1902.
Plate 10	Isolation hospital, Lerwick.
Plate 11	Man giving directions to Nurse Margaret Davidson, Foula.
Plate 12	Mary Breckinridge, founder of the Kentucky Frontier Nursing Association.
Plate 13	Kentucky Frontier Nurses on horseback.
Plate 14	District Nurse with car, Shetland, <i>c.</i> 1930s.

## LIST OF APPENDICES

Appendix 1	Can This Be The land?
Appendix 2	Dewar Committee biographical details.
Appendix 3	Return of Information from Medical Practitioners, 1912.
Appendix 4	Circular letter, sent by Board to localities, 15 January 1914.
Appendix 5	Medical witnesses to the Dewar Enquiry.
Appendix 6	Highlands and islands (Medical Service) Grant Act 1913.
Appendix 7a	Highlands and Islands Medical Service Contract (Page 1).
Appendix 7b	Highlands and Islands Medical Service Contract (Page 2).
Appendix 8	Public Notice of Arrangements Between The Highlands And Islands Medical Service Board and Medical Practitioners, 1917.
Appendix 9	Statement Showing the Amount and Distribution of the Total Work in 1917 of Practitioners for 114 Practices Working Under Arrangements with the Board, and the Like Information For 116 Practices in 1918.
Appendix 10	Consultative Council on Highlands and Islands Personnel, 1920.
Appendix 11a	Registration card, 1920.
Appendix 11b	Work Card, Queen's Nurse, 1920.
Appendix 12	List Of Nursing Associations In Outer Isles Subsidised By [HIMS] Board, 1916.
Appendix 13	An account of a Queen's nurse taking up duty in the Outer Hebrides in Midwinter, c.1920.
Appendix 14	Nurses employed in the Highlands and Islands in 1917

## **LIST OF ABBREVIATIONS**

BMA	British Medical Association
BMJ	British Medical Journal
HIMS	Highlands and Islands Medical Service
SBH	Scottish Board of Health
DHS	Department of Health for Scotland
LA	Local Authority
MOH	Medical Officer of Health
MRG	Medical Relief Grant
NA	Nursing Association
NHI	National Health Insurance
NHS(S)	National Health Service (Scotland)
QNI	Queen's Nursing Institute
QVJIN	Queen Victoria's Jubilee Institute for Nurses
RCN	Royal College of Nursing
NRS	National Records of Scotland (Incorporates National Archives of Scotland)
NLS	National Library of Scotland
P&K Archive	Perth & Kinross Archive
Atholl MSS	Blair Atholl Castle Archive
SIA	Shetland Island Archive
OIA	Orkney Island Archive
RCPE	Royal College of Physicians of Edinburgh
TNA	The National Archives

## INTRODUCTION

The primary purpose of this thesis is to examine the institutional infrastructure facilitating the development of medical and nursing services in the Highlands and Islands of Scotland in the latter half of the nineteenth century and first three decades of the twentieth century.<sup>1</sup> Developments throughout that period led to the establishment of the Highlands and Islands Medical Service (HIMS) in 1913. Uniquely in the United Kingdom and further afield it provided a state subsidy to general practitioners and was reported in 1936 as having ‘revolutionised medical provision in the Highlands and Islands area’, a statement that will be considered critically throughout this study.<sup>2</sup> The period under examination is 1843, the beginning of the modernisation of the Scottish Poor Law and the development of the Poor Law Medical Service, to 1936 when the Committee on Scottish Health Services (the Cathcart Committee) reviewed the state of Scottish health services.<sup>3</sup> Specifically, within this chronology, the main emphasis is on the period from 1880, when a number of important political and public health developments occurred, leading to the Dewar Enquiry and the establishment of the Highlands and Islands Medical Service, to the Cathcart Enquiry in 1936, which reviewed Scottish medical services.

The Poor Law (Scotland) Act 1845 transferred the responsibility for the management of the registered poor from the Church of Scotland to the State. A new central administrative body, the Board of Supervision, was created, with oversight of newly formed local Parochial Boards, which had the power to raise funds at the local level by assessment. In 1847 a Medical Relief Grant was set up which required that all participating parishes should appoint legally qualified medical officers, with fixed salaries, to attend the registered poor with the intention of increasing the efficiency of medical relief to that specific section of the population.<sup>4</sup> Till the first decades of the twentieth century the Poor Law Medical Service often provided the sole medical practitioner available to both the registered poor and the general public in remote areas. Of wider significance, it represented the start of the development of state

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<sup>1</sup> The medical service was brought into operation by the *Highlands and Islands (Medical Service) Grant Act*, 1913.

<sup>2</sup> Report of the sub-committee appointed to consider their remit in the Highlands, quoted in the report of the *Committee on Scottish Health Services* (the Cathcart Report), Cmd.5204, 1936, p.225.

<sup>3</sup> *Report of the Committee on Scottish Health Services*, Department of Health for Scotland, Cmd. 5204, 1936.

<sup>4</sup> The Medical Relief Grant was established by Parliament during the financial year 1847-48 as part of John Peel’s scheme to relieve local rates, *Local Government Board Report on Poor Law Medical Relief*, Volume I, Part 3/5, 1904, p.6.

responsibility for the health of the population, which continued to gather momentum throughout the remainder of the nineteenth century and into the twentieth century, culminating in the establishment of the National Health Service in 1948.<sup>5</sup>

Developments in public health were integral to this process, within the framework of the increasing role of the state in welfare reform.

The wealth of government enquiries and reports relating to the Highlands and Islands during the nineteenth and early twentieth centuries make it possible to understand and piece together a small part of the lives of poor crofting communities. Many of the doctors and nurses in the Highlands took up positions with little or no knowledge of the social and cultural environment or language, which in many areas was predominantly Gaelic. Working under difficult physical conditions they were often faced with bureaucratic barriers to their work and intransigence from the local communities. Women doctors often had to prove they were not ill equipped as women to face the often arduous conditions of the Highlands and Islands but paradoxically were recruited in areas where male doctors were unwilling to work.

During the nineteenth century the period under examination experienced increasing government interest and active intervention in the Highlands. Geographically remote from the lowland centres of industrial power, this region occupied a growing and disproportionate level of government time and consideration. In earlier decades famine, clearance, the development of large-scale pastoral farming and mass emigration all occurred with little explicit popular protest and with only limited government intervention.<sup>6</sup> In the later nineteenth century, in sharp contrast with earlier decades, land agitation leading to the passage of the Crofters Act in 1886<sup>7</sup> and other land based legislation, including the establishment of the Congested Districts Board in 1897, drew public attention and finally engaged government fully and irrevocably with the Highland 'problem'.<sup>8</sup>

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<sup>5</sup> H. Dingwall, *A History of Scottish Medicine*, Edinburgh, 2003; M. McCrae, *The National Health Service in Scotland*, East Lothian, 2003.

<sup>6</sup> The limited level of government intervention in the Highlands during the famine is detailed in Chapter 5, *The Provision of Relief*, pp.111-145, T.M. Devine, *The Great Highland Famine*, Edinburgh, 1988.

<sup>7</sup> *The Crofters' Holdings (Scotland) Act*, 1886, granted security of tenure to all crofters paying rent of less than £30 a year within the seven crofting counties of Argyll, Inverness-shire, Ross and Cromarty, Sutherland, Caithness, Orkney and Shetland, subject to certain conditions and administered by the Crofters' Commission till 1912, when that particular body was dissolved, many of its functions taken over by the Scottish Land Court.

<sup>8</sup> The Congested Districts Board was established under the terms of the Congested Districts (Scotland) Act, 1897. Its main aims were to aid and develop agriculture, the fishing industry and home industries such as spinning and weaving, provide land, improve lighthouses, harbours, piers, roads and bridges and aid the migration of cottars and crofters from the congested districts of the seven crofting counties to other parts of Scotland.



The issues that led to land agitation during this period were complex and were exacerbated by world economic conditions, leading to increasing levels of poverty and destitution in many areas of the Highlands, most notably the west coast and islands. That also served to reinforce governmental concern about the prevailing political, social and economic conditions in the Highlands. Poverty and ill health in the late nineteenth century were never central issues within governmental policy in the Highlands, but were an accelerant to those bigger issues. Famine had exposed the vulnerability of the Highland population, which was clearly ill equipped to withstand natural disasters and economic downturn. An area that traditionally had provided men for the militia, it failed to deliver when the search for new recruits during the Boer War revealed universal poor health levels throughout Scotland. Within the context of the Liberal reforms of the early twentieth century, this gradual growth in awareness of the health and medical care issues in the Highlands can be viewed as an important factor in the passage of the Highlands and Islands Medical Services Act in 1913.<sup>9</sup>

The establishment of numerous governmental enquiries and a raft of legislation specific to the Highlands demonstrate an unprecedented level of central governmental intervention in the region during this period. From being an area requiring active intervention to create pacification and stability, as the nineteenth century progressed the Highlands were increasingly viewed more sympathetically as a special case requiring special treatment.<sup>10</sup> The expansion in government interventionist activity designed to both enable and enforce, and the subsequent legislation designed to improve public health was implemented throughout Scotland, but the particular circumstances of the Highland counties demanded a distinctive approach throughout that area. Changing social and economic conditions in the Highlands and greater exposure to southern market forces had fundamentally altered the nature of Highland society which, by the 1880s, had a greater participation in the cash economy and which was less directly dependent on the land – though still with great variations

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<sup>9</sup> General literature on welfare reforms include B.B. Gilbert, *The Evolution of National Insurance in Great Britain, the Origins of the Welfare State*, London, 1966; M. Bruce, *The coming of the Welfare State*, London, 4<sup>th</sup> edition, 1968; Hay, *The Origins of the Welfare Reforms*, London, 1975; I. Levitt, *Poverty & Welfare in Scotland, 1890-1948*, Edinburgh, 1988; G. Finlayson, *Citizen, State and Social Welfare in Britain 1830-1990*, Oxford, 1994; J. Harris, *Private Lives, Public Spirit: A Social History of Britain, 1870-1914*, Oxford, 1993; A. Sykes, *The Rise and Fall of British Liberalism*, London, 1997; A. Digby & J. Stewart, *Gender, Health & Welfare*, London, 1996.

<sup>10</sup> These issues are discussed in detail in Cameron, 'Public Policy in the Scottish Highlands', unpublished Ph.D. thesis, 1992 and in T.M. Devine, *Clanship to Crofter's War: The Social Transformation of the Scottish Highlands*, Manchester, 1994 and *The Scottish Nation*, London, 2000.

throughout the Highlands.<sup>11</sup> The relatively stable economy in the decades after the famine, till the 1870s, facilitated faltering advances, aided by limited improvements in transportation by sea and road. The geographic isolation and topography of the Highlands, however, remained a major hindrance to modernisation and the main sources of income available to the majority of the Highland population: fishing, cattle trade and seasonal labour were traditionally vulnerable to external economic factors.

A number of years ago, Smout stated ‘If one was to consider only the Hebrides, the Highland problem of this period would appear to be created entirely by the pressure of population on resources, and to be one to which clearances and sheep farming were largely irrelevant’.<sup>12</sup> The situation, of course, was one of variation across the region; the Highlands need to be understood within a wider social, political and economic context. Gray first documented the distinction between the remote and crowded north and west and the more (relatively) affluent south and east Highlands some years ago.<sup>13</sup>

An emphasis, however, on the Western seaboard and Hebrides is difficult to avoid. The economic downturn of the 1880s led to widespread distress in many areas, particularly in the western islands. It highlighted both the deficiency of medical provision and the difficulties faced by the doctors and nurses who worked in the Highlands. The distress ensuing from the 1880s was widely documented in a series of government enquiries, including the Napier Commission, which examined the condition of the population in the 1883, the condition of the cottar population in the Lews in 1888; the Deer Forest Commission in 1892; the sanitary condition of the Lews in 1905; the burden of rates and the general financial position of the Outer Hebrides in 1906 and the Royal Commission on the Poor Laws and Relief of Distress in 1909. The western seaboard and, in particular, the Western Isles, dominate many of these enquiries, reflecting the impact of the pressure on the population and economy. Consequently, many of the examples used originate in that area, reflecting the wealth of detailed statistical and qualitative data that does not exist in the same detail for other regions of the Highlands. This is not, however, to imply that distress did not exist in those areas, but rather, in areas where subdivision was not the norm, it was

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<sup>11</sup> Devine, *Clanship to Crofter's War*, pp.200-207.

<sup>12</sup> T.C. Smout, *A History of the Scottish People 1560-1830*, London, 1961, p.351.

<sup>13</sup> M. Gray, *The Highland Economy 1750-1850*, Edinburgh, 1957. ‘Sketch map showing the main demographic zones’, p.2.

not so intensely concentrated in one region and therefore did not receive the same scale of enquiry and documentation.

Despite Professor Roy Campbell's article 'Too much on the Highlands? A plea for change' in 1994 there is still much valuable research to be carried out on aspects of Highland history.<sup>14</sup> His assertion, that 'romantic notions' of the Highlands had concentrated scholars' minds on Highland landlordism – mainly linked to the clearances – to the detriment of study of the Lowlands has long since been redressed. Recent Highland historiography, however, though plentiful, has till recently focused on mainstream social, political and economic history. Cameron's work on the development of public policy in the Highlands therefore provides an invaluable contextual framework for this study into Highland medical services. In a series of seminal publications he examines the development of a specific Highland policy area from the 1880s and the strategies employed by the government to maintain it.<sup>15</sup>

A growing body of scholarship has examined the gradual expansion in state intervention in the health of the population, notably from 1845, when the Poor Law (Scotland) Act transferred responsibility for its administration to the state from the Church of Scotland. Earlier works on the Old Poor Law and the transition to the new regime, such as Cage and Levitt and Smout's work on the *State of the Scottish Working Class in 1843*, provide detailed data and analysis facilitating comparison with later decades. The most relevant contemporary text is Day's *Public Administration in the Highlands and Islands*, published in 1918, but written before the First World War.<sup>16</sup> This text alone focuses on the Highlands.

Levitt's work on Scottish public policy has examined in detail the development of public health policy and the Scottish agencies which managed it. He assesses the origins of the Welfare State within the Scottish context, which provides very useful

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<sup>14</sup> R.H. Campbell, 'Too much on the Highlands? A plea for change', *Scottish Economic & Social History*, 14, 1994, pp.58-76. This article concentrated on rural agriculture and focused on his belief that the study of Scottish rural history was dominated by the Highlands, engendered by 'romantic notions'. A recent publication stresses the industrial history of the Highlands but fails to acknowledge the sharp contrasts between the poor west and more affluent central and southern regions of the Highlands in which industry, including iron smelting and aluminium production, was situated, A. Perchard and N. Mackenzie, 'Too much on the Highlands?: Recasting the Economic History of the Highlands and Islands, *Northern Scotland*, 4, 2013, pp.3-22.

<sup>15</sup> E. Cameron, *Land for the People?: The British Government and the Scottish Highlands, c.1880-192*, Edinburgh, 1996; 'The Scottish Highlands as a Special Policy Area, 1886 to 1965, *Rural History*, Vol. 8, 2, pp.195-215; 'Communication or separation? Reactions to Irish land agitation and legislation in the Highlands of Scotland, c.1870-1910', *English Historical Review*, CXX, No. 487, 2005.

<sup>16</sup> R.A. Cage, *The Scottish Poor Law, 1745-1845*, Edinburgh, 1981; I. Levitt and C. Smout, *The State of the Scottish Working Classes in 1843*, Edinburgh, 1979; J.P. Day, *Public Administration in the Highlands and Islands of Scotland*, London, 1918.

and illuminating detail on the issues in Scotland, particularly in its contextual relationship to other social and political issues of the period. Both his extended introduction to *The Scottish Office, Depression and Reconstruction 1919-1959*, which clarifies the evolving administration of Scotland within the context of Westminster (followed by commentaries on a selection of sources, including the Cabinet papers and the Scottish Board of Health) and guide which details the Scottish papers submitted to the Cabinet from 1917-1945, are useful in de-mystifying the bureaucratic administrative processes of parliament and analysing the roles of the chief players.<sup>17</sup> Jenkinson, in *Scotland's Health 1919-1948*, examines the development and impact of the Scottish Board of Health, which was responsible for the HMS, and its relationship and degree of autonomy, with the Ministry for Health. The section on the Highlands and Islands is brief but one of its strengths is the detailed account of aspects of the administrative infrastructure and the development of public health in Scotland. Jenkinson has also written the sole work the role of Scottish medical societies and the development of the medical profession. Although information on the Highlands is minimal, information on the relationship between the medical and ancillary professions, such as midwifery, provides useful contextual information. Equally, Stewart's work on the creation of the National Health Service, the Poor Law and welfare provides a valuable context for this research. *Gender, Health & Welfare* contains a very useful synthesis, surrounding the development of 'New Liberalism', and is unusual in the inclusion of gender debates in this subject.<sup>18</sup>

Dingwall's general history of Scottish medicine provides an overview over a significant period of both medical and social developments that is also helpful in setting the context of the Highlands in the Scottish experience. Checkland focuses on the role of philanthropy in the development of medical services in Scotland, which was important in some areas of the Highlands.<sup>19</sup> McCrae, in his analysis of the origins of the National Health Service in Scotland, addresses issues of medical provision in the Highlands, but views both the Poor Law Medical Service and the HMS uncritically as proto-National Health Services, when neither were comprehensive in

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<sup>17</sup> I. Levitt, *Poverty & Welfare in Scotland 1890-1948*, Edinburgh, 1988; *The Scottish Office, Depression and Reconstruction 1919-1959*, Edinburgh, 1992; Scottish Papers Submitted to the Cabinet, 1917-45: A guide to Records Held at the Public Record Office and National Archives of Scotland, *Scottish Economic and Social History*, 19, 1999.

<sup>18</sup> A. Digby & J. Stewart, *Gender, Health and Welfare*, London, 1996.

<sup>19</sup> J. Jenkinson, *Scotland's Health 1919-1948*, Oxford, 2002 and *Scottish Medical Societies, 1731-1939, Their History and Records*, Edinburgh, 1993; H.M. Dingwall, *A History of Scottish Medicine*, Edinburgh, 2003; O. Checkland, *Philanthropy in Victorian Scotland: Social welfare and the voluntary principle*, Edinburgh, 1980.

level of service or eligibility.<sup>20</sup> Stewart's work on the distinctiveness of the National Health Service in Scotland is unique in demonstrating through examination of the Cabinet and Department of Health for Scotland papers in The National Archives and the National Records of Scotland, that despite the constraints of the Treasury, which also hindered the development of the Highlands and Islands Medical Service (HIMS), the National Health Service in Scotland had a number of areas of distinction, including the features of remoteness that influenced the establishment of the HIMS. The point is made that by the 1940s it was clear that Scotland would have a separate National Health Service.<sup>21</sup>

This examination of the changing nature of medical provision during this period of social and economic transition, is carried out within the wider context of public policy in the Highlands. A doctoral study of General Practice in the Scottish Islands by Collacott was an early study of medical issues of the Highlands outlining general practice from the twelfth century to the 1980s.<sup>22</sup> It, necessarily, within the long time frame addressed, was unable to provide detailed analysis but provides useful local data on island practice, particularly Orkney. Other early publications provided a strong basis for modern research with works including *The Highland Economy 1750-1850* by Malcolm Gray, which was an important publication, one of the first to focus academic discussion on the Highlands on economy and population, within the context of industrialisation. Earlier writings concentrated on the clearances and emigration.<sup>23</sup> The critically important *Scottish Population History* by Michael Flinn, provided for the first time a detailed and comprehensive analysis of Scottish demography.<sup>24</sup>

The late eighteenth to twentieth century social, political and economic history of the Highlands has in recent years been researched widely by historians of Scotland, including Cameron, *Land for the People?: The British Government and the Scottish Highlands, c.1880-1925*; Smout, *A Century of the Scottish People*; Richards, *The Highland Clearances: People, Landlords and Rural Turmoil*; Devine, *The Great Highland Famine, Clanship to Crofters' War: the social transformation of the Scottish Highlands*, and 'Temporary Migration and the Scottish Highlands in the

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<sup>20</sup> M. McCrae, *The National Health Service in Scotland*, East Linton, 2003.

<sup>21</sup> J. Stewart, 'The National Health Service in Scotland, 1947-74, Scottish or British?', *Historical Research*, 76, 193, 2003.

<sup>22</sup> R. Collacott, *A study of the development of general practice in the Scottish Islands*, unpublished PhD thesis, University of Leicester, 1982.

<sup>23</sup> For example, A. Mackenzie, *The History of the Highland Clearances*, Inverness, first published in 1883.

<sup>24</sup> M. Flinn, (ed.) *Scottish Population History from the Seventeenth Century to the 1930s*, Cambridge, 1977.

Nineteenth Century; Hunter, *The Making of the Crofting Community*, Tindley, *The Sutherland Estate, 1850-1920: aristocratic decline, estate management and land reform*. These heavily empirical texts, the products of detailed primary research, are enormously useful in clarifying and illuminating the complexity of the Highland 'problem'.<sup>25</sup> A more recent text by Burnett, *The Making of the Modern Scottish Highlands, 1939-65*, adds to an expanding body of research into twentieth Scottish Highlands, led to date by Cameron. It adopts a holistic approach, addressing social, economic, cultural and linguistic issues and suggests that although the economic and social developments of the early twentieth century appeared to have resolved many of the areas of conflict, pressures, which remained 'between the old and the new', were not resolved:

On the surface, land settlement, reformed local government, an enhanced provision of social services and improved integration into the communications and public administration infrastructure at national level might have given the impression that the era of the old 'Highland problem' was at an end but within the social and cultural fabric of the region the stresses of unresolved issues were palpable.<sup>26</sup>

Increasingly, a new body of scholarship in the form of doctoral theses is developing which is opening up new areas of study and which is challenging the interpretations of established historians. For example, Leigh Ann Merrick, who has examined the role of local authorities in the establishment of the NHS in Scotland, argues that the consensus between central and local health service providers and the medical profession, documented by McCrae and Jenkinson in the process leading to the NHS(S), masked internal conflict. She cites the HIMS, under central administration within the Scottish Board of Health and later the Department of Health for Scotland (DHS), as smoothing the passage of central control of the NHS in Scotland.<sup>27</sup> Other

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<sup>25</sup> Cameron, *Land for the People*; T.C. Smout, *A Century of the Scottish People 1830-1850*, London, 1986; T.M. Devine, *The Great Highland Famine, Clanship to Crofters' War & 'Temporary Migration and the Scottish Highlands in the nineteenth century'*, *Economic History Review*, 32, 1979; J. Hunter, *The Making of the Crofting Community* (2<sup>nd</sup>. edition), Edinburgh, 2000; E. Richards, *A history of the Highland clearances. Vol.1, Agrarian transformation and the evictions 1746-1886*, London, c1982; *The Highland Clearances: People, Landlords and rural Turmoil*, Edinburgh, 2008; *Debating the Highland Clearances*, Edinburgh, 2007; A. Tindley, *The Sutherland Estate, 1850-1920: aristocratic decline, estate management and land reform*, Edinburgh, 2010. Others, including Marjory Harper and Charles Withers, have included the Highlands in Scottish-wide studies of emigration.

<sup>26</sup> Burnett, *Making of Modern Scotland*, p.15.

<sup>27</sup> L.A. Merrick, unpublished PhD Thesis, 'Local Authorities and the Development of the National Health Service (NHS) in Scotland, 1939 to 1974, University of Glasgow, 2008. The experience of managing the HIMS and other 'social experiments', providing it with a precedent and strengthening the argument for Scotland to retain control over its health services, is also raised by the report of the Committee on Scottish Health Services, in the Cathcart Report; M. McCrae, *The National Health Service in Scotland: Origins and Ideals, 1900-1950, East*

postgraduate studies on midwifery and district nursing illuminate the definitions and working practices of these distinct branches of nursing. They set their development within defined time periods in the context of general nursing, and reveal how both district nursing and midwifery evolved into recognised areas of the profession, previously dominated by general nursing. Though not necessarily in the Highlands, or even Scotland, they provide valuable comparative information on areas of practice and attitudes. A body of literature both on nursing generally and also specifically within rural areas, is growing, which demonstrates that the conditions in the Highlands were echoed in many other parts of the world. Publications such as *New Directions in the History of Nursing*, examine issues including the relationship between nursing and the state, nursing and the medical profession and the organisation of nursing societies. Journals include the *British Journal of Nursing* and the *Canadian Nurse*, both available online, contain contemporary reports and case studies.

There is no single study of the Highlands that attempts to chart the development of medical services in the Highlands in the context of the development of public health policy and assess its contribution to general levels of health. In addition, a key omission from existing works in this field, which due to time and space restraints can only be briefly referred to in this work, which is essentially examining administrative structures, is the comparative context. It provides rich material for future research. The physical conditions and the professional, social, economic and political contexts and issues faced by medical practitioners and nurses in the Highlands were mirrored by the medical profession in other remote areas of the world, including the USA, Canada, Australasia, Scandinavia and Russia, as well as other rural regions of the UK and Ireland. Parallels and contrasting experiences of the development of the nursing and medical professions, the difficulties arising from remoteness and the response of government provide rich data and a more meaningful analysis.

Books and articles on nursing in Canada and Australia, where the historiography is more advanced, provide the international perspective. They include *Suitable for the Wilds: Letters from Northern Alberta 1929-1931*, which chart the experiences of a female doctor from Birmingham, Dr Mary Percy Jackson, who worked alone in North

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Linton, 2003; S. Blackden, 'The Board of Supervision and the Scottish Parochial Medical Service 1845-95, in *Medical History*, 1986, 30, pp.145-172.

west Alberta, in a district which covered 250 miles, on the edge of the Rockies. The advert she answered requested ‘Strong energetic Medical Women with post graduate experience in Midwifery’, which would have suited work in the Highlands exactly.<sup>28</sup> Others include *These Were Our Yesterdays: A History of District Nursing in Alberta*; *Angels of Mercy: District Nursing in South Australia 1894-1994* and *Making a difference; The History of Canada’s Nurses*, and *Between Community and State: Practicing Public Health in Cape Breton 1938-1948*, which contain details and experiences of the working conditions of nurses in isolated areas in Canada and Australia and the relationship and interaction of nursing history with mainstream history.<sup>29</sup>

A recent addition to the historiography surrounding this subject is *Medicine in the Remote and Rural North, 1800-2000*, which examines issues surrounding the provision of medical services in remote areas of Northern Europe and North America.<sup>30</sup> The North is defined as a concept rather than a specific geographical location; the articles within this edited collection essentially defining and examining the relationships between ‘core’ and ‘periphery’ including (of particular relevance to this study) the increasing role of the state in the provision of medical services, the interaction of and relationship between new medical providers and local populations (and also between doctors and nurses) and the conditions faced by them in those remote areas. Marguerite Dupree uses the example of the centralised HIMS to examine weaknesses in the tri-partite organisation of the National Health Service, which also illustrates the differences between both organisations.<sup>31</sup>

This study, therefore, will build upon existing historiography in the areas of the public administration of the Highlands. In addition to the secondary texts, contemporary reports and other printed sources, the other key resources are the primary archival collections held throughout Scotland, including the government papers held in the National Records of Scotland (NRS) and the Cabinet papers held in The National

<sup>28</sup> J. Dickin, (ed.), *Suitable for the Wilds: Letters from Northern Alberta 1928-1931*, Calgary, 2006.

<sup>29</sup> B. Mortimer and S. McGann, (..), *New Directions in the History of Nursing: International Perspectives*, Oxford, 2005; I. Stewart, (ed.), *These Were Our Yesterdays: A History of District Nursing in Alberta*, Calgary, 1979; R. Linn, *Angels of Mercy: District Nursing in South Australia 1894-1994*, Norwood, South Australia, 1993; V. Strong-Boag, *Making a difference; The History of Canada’s Nurses*, *Canadian Bulletin of Medical History*, pp.231-48, 8, 1999; S. Mullally, *Between Community and State: Practicing Public Health in Cape Breton, 1938-1948*, *Acadiensis: Journal of the History of the Atlantic Region*, 38, 2, 2009, pp.98-115.;

<sup>30</sup> J.T.H. Connor & S. Curtis (eds.) *Medicine in the Remote and Rural North, 1800-2000*, London, 2011

<sup>31</sup> M. Dupree, ‘Foreshadowing the future: Health Services in Remote Areas, the National Health Service and the Highlands and Islands of Scotland, 1948-74’ in Connor & Curtis (eds.). *Medicine in the Remote and Rural North, 1800-2000*.



Archives (TNA) in London. Local authority archives provide, in their parish records, information on the local situation. Other collections, such as that of the Queen Victoria Nursing Institute, based in London, but which also operated in Scotland from Edinburgh with its own Council, provides detailed information on the training and conditions of ‘Queen’s Nurses’ the trained nursing workforce of Scotland which developed during the early twentieth century.<sup>32</sup> The Archive contains reports, nursing files and other information that provides a profile of the nurses (including place of origin and place of work), training, experience and administration. The few publications on the Institute include *A History of the Queen’s Nursing Institute: 100 Years 1887-1987*, by Monica Baly, which barely mentions the Scottish branch, and an article by Margaret Damant on the biographical profile of Queen’s Nurses in Britain, which does not refer to Scotland at all.<sup>33</sup> Another major source is the wealth of information on conditions in the Highlands during this period, which is contained in reports produced by bodies such as the Medical Research Council, such as a study on dental disease on Lewis, which contain vital details on health and nutrition not available elsewhere.<sup>34</sup>

The research for this study has been greatly facilitated by the increasing availability of online searchable primary, secondary and printed sources, within the UK and further afield. The ability to search local and national online newspapers such as *The Times* and *The Scotsman* and journals, such as the *British Medical Journal*, simultaneously reduces research time and increases the quantity of source material accessed.

Likewise, the digitisation of the UK Parliamentary Papers, including Command papers, Bills and Acts, House of Commons and Lords debates, and Hansard debates enables, by its sheer comprehensiveness, full interrogation and analysis of a vital resource which was previously time-consuming and complicated, making it difficult to identify and locate appropriate items. The Office of the Registrar General has made available online the Old Parish Registers, civil registers and Census. Statistical data, compiled from the reports of the Registrar General for Scotland, provide detailed

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<sup>32</sup> The Queen’s Nursing Institute Scottish collection is held in the Royal College of Nursing Archives in Edinburgh.

<sup>33</sup> M. Baly, *A History of the Queen’s Nursing Institute: 100 Years 1887-1987*, London, 1987; M. Damant, ‘A biographical profile of Queen’s Nurses in Britain 1910-1968’, *Social History of Medicine*, 23, 3, pp.586-601, 2010.

<sup>34</sup> J.D. King, *Dental Disease in the Island of Lewis*, Special Report Series, Medical Research Council, p.241, London, 1940.

mortality data at the local level.<sup>35</sup> The National Records of Scotland have the complete series of Wills and Testaments among other online resources. This phenomenon is part of a wider trend of archives placing both catalogues and digitised items online; the former enabling much initial trawling of sources to be done without the need to travel; the latter providing immediate access to archives and photographs. Issues of contextuality and representativeness, arising from the often incomplete nature of such resources, have been accounted for when using online archival items in this study.

An overview of developments made under the Poor Law provides important contextual background to the research, followed by an examination of the 1880s to the 1930s, when government intervention in public health underwent an expansion in the nature and scale of improvements in sanitation, maternity and child welfare, education and other related areas. A major force was the Local Government (Scotland) Act of 1889, which changed the face of Scottish Local Government by establishing county councils, responsible for ‘the management of the administrative and financial business’ of the county, with a major remit to improve the state of public health.<sup>36</sup> The newly instituted county councils set in place the political and administrative infrastructure, under which wide ranging and expansive public health improvements were instituted. At the end of the period under consideration, in 1936, the Scottish Health Services Committee published the Cathcart Report, which reviewed the existing state of health services in Scotland ‘in the light of modern conditions and knowledge’, and though never implemented, still provides a useful comparator to the earlier period.<sup>37</sup> The Committee reported the success of the HIMS in improving the provision of medical and nursing services and providing a vision for the rest of Scotland and is cited as providing a vision for the future National Health Service. The conclusions of the Cathcart report will be assessed to provide a more balanced view of the impact of the HIMS.

Prior to the HIMS, the Parochial Medical Officers, employed for the relief of the poor, were, in many areas of the Highlands, the only recourse to medical treatment for the majority of the population. They shared many of the hardships suffered by the general population in these remote areas: inclement physical conditions, poor

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<sup>35</sup> Annual detailed reports of the Registrar-General for Scotland are available at; <http://www.gla.ac.uk/departments/scottishwayofbirthanddeath/>.

<sup>36</sup> W.E. Whyte, *Local Government in Scotland: with complete Statutory References*, (2nd ed), London, 1936, p.7.

<sup>37</sup> Minute of Appointment and Terms of Reference, *The Cathcart Report*, p.3.

communications, scattered remote communities, inferior housing conditions and, crucially, for professional practitioners, inadequate and unpredictable remuneration. It is within this context that the growth and development of medical services and changes in levels of health in this period will be analysed. The influence of landscape, transportation and communication developments are briefly surveyed in Chapter One, providing the contextual background for an examination of the existing state of Highland medical services in the early years of the new Scottish Poor Law.

Chapter Two establishes the nature and scale of medical services in the Highlands from 1844 to 1880. The Poor Law Amendment (Scotland) Act of 1844 established the infrastructure for the administration of poor relief in the period under consideration. Its effectiveness will be examined, within the context of local government reform and increasing government involvement in the Highlands. The establishment of the Medical Relief Grant in 1847 encouraged the employment of medical officers in the Highlands and increased the influence of the Board of Supervision over the Parochial Councils. An important source for this period is the report of the Physicians Enquiry, established in 1850, to investigate general levels of health and the extent of medical care in the Highlands, which provides very useful comparative information to ascertain later changes and improvements.

The next chapter, Chapter Three, continues to examine the development of medical services from 1880 to 1912, within changing political and social contexts. The Medical Relief Grant was expanded and established attitudes towards illness and the poor were increasingly challenged. As traditional liberal laissez-faire values were being eroded, government intervention in the lives of individuals was becoming more prevalent. Chapter Three also identifies the nature and scale of medical practitioners, nurses and hospitals and outlines and discusses the proportion of the non-pauper population and their access to medical services. This is a crucial period during which many of the foundations for future developments in health services were laid. It was a period of instability with serious economic depression and political agitation but which also experienced increasing social awareness of the causes and impact of poverty on health, and many medical advances. Many factors converged towards the turn of the century; economic depression, land wars, increasing destitution in the western Highlands and a radical, modernising Liberal government. The First World War recruitment drives effectively highlighted the poor general health of the nation,

bolstered by the National Efficiency Movement.<sup>38</sup> Concurrently, the debates leading to the National Insurance Act in 1911 intensified the prevailing view, discussed at length in Parliament, that poverty in the Highlands would prevent the new legislation being fully implemented.<sup>39</sup> This was undoubtedly a key factor in the establishment of the Highlands and Islands Medical Services Committee.<sup>40</sup>

Chapter Four considers and assesses the reasons for the establishment of the Committee in 1912, which investigated the level and effectiveness of medical services in the Highlands and Islands. Attributed by most writers on the subject as being a direct result of the National Insurance Act – though only a small minority of the Highland population were eligible under the Act – this chapter will argue that other longer-reaching factors were also important in providing the background and context for its establishment. They include the gradual recognition of the Highlands as a special area with special requirements, which generated legislation specific to the Highland region; the land wars and associated unrest which continued into the early twentieth century; increasing government intervention and ‘new liberalism’, which provided a partial shift from the laissez-faire of the earlier nineteenth century.

Chapter Five examines the methodology and findings of the Dewar Committee and its recommendations. In addition to purely health and medical information the detailed enquiry also gathered diverse evidence on wider social and economic factors. The report provides a detailed snapshot of life in the Highlands in 1912 at the local level. The Dewar Enquiry and Report led to the Highlands and Islands Medical Service Act and the subsequent establishment of the Highlands and Islands Medical Service Board in 1913. Chapters Four and Five are both written within the political context of ‘new liberalism’ and the National Insurance Act.

Chapters Six and Seven examine the HIMS, which provided medical attendance for the whole Highland population within the selected counties, regardless of status or income. While it appears to be a radical departure from the principle of self-help and means-testing, which is how it has been portrayed by writers about the HIMS, the principle of self-help was, in reality, firmly imbued in the development and operation

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<sup>38</sup> G.R. Searle, *The Quest for National Efficiency: A Study in British Politics and Political Thought 1899-1914*, (2<sup>nd</sup> Ed.), London, 1990.

<sup>39</sup> *HC Debates*, 18 March 1912, vol. 35, cc1519-21. *Hansard* online provides a comprehensive record of the debates surrounding the passage of the Act.

<sup>40</sup> The main sources for this chapter are the British Parliamentary Papers, contemporary accounts and publications and recent academic publications which have significantly illuminated Scottish medical and Highland history.

of the service in the form of required local contributions; all financial expenditure was monitored closely by the Treasury. It was, nevertheless, one of the last Liberal reforms, notable by its smooth and speedy passage through parliament, with little or no dissent.<sup>41</sup> It aimed to provide general practitioners for the whole of the Highland population, and to secure for the doctors improved conditions of employment and a reasonable remuneration. It has been cited as ‘a comprehensive state medical service’, and a ‘forerunner to the National Health Service’ assertions that will be examined.<sup>42</sup> Although it will be argued that the extent and impact of the service within the wider national context has been overstated, it was nevertheless crucial to the improvement of medical services in the Highlands and unique in its establishment.

Public health interventions, including general sanitation improvements in the late nineteenth century and increased household cleanliness, encouraged by district nurses, improved maternity care, housing, diet and employment all influence levels of health and, together with statistical analysis, offer possible explanations for decreasing patterns of infant mortality. A more detailed statistical analysis is not possible within the constraints of this study but represents an important theme for future research.

One of the most effective ways in which medical care could be improved in the Highlands was by the employment of trained nurses, which provided a local and trusted link between the community, private practice and the poor law service and the developing public health services. Many nurses trained by the Queen Victoria Institute in Edinburgh originated in the Highlands, returning to their home districts following their professional training. Chapter Eight charts the development, growth and importance of district nursing in the remote areas of the Highlands and Islands, within the context of the HIMS. Nursing provision was important everywhere; in remote and sparsely populated Highland districts it was a vital element of health care provision and, as in many rural areas throughout the world, assumed distinctive characteristics. Nurses and nursing traditionally exemplified the feminine attributes of compassionate and nurturing, nurses portrayed as heroic, gentle and guided by a strong, caring vocation. Whether informally known at the local level as nurses or midwives, or later in the early twentieth century, as trained professionals, they were, paradoxically, required to work in very challenging environments which required

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<sup>41</sup> Dissent was mild and focused mainly on the area designated as within the HIMS, not on the principle itself.

<sup>42</sup> McCrae, *The National Health Service in Scotland*, p.14.

them to have physical strength, resilience and an intellectual approach to their professional careers, with little to compare them to the widely published and depicted romanticised role of the nurse.

To identify the crucial role of nurses within the context of Highland medical provision, this chapter examines the scale, nature and function of nurses in the Highlands, their training and their relationship and contribution to the HIMS. There are many international comparators, including the Kentucky Frontier Nursing Service, which was established with the assistance of a trained Queen's Nurse from the Highlands.

Within the later chapters the broader implications of the imposition of enforced policies and practices on the Highland society are considered. Connor and Curtis addressed issues arising from governmental and other external bodies' involvement in remote areas. While they examine the relationship between core and peripheral communities they reject the perception of such marginal areas as 'inherently passive peripher(ies)' - merely acting as recipients from a dominant core, or centre. They instead adopt a more positive approach which 'explore(s) the mechanisms that enabled those relationships to serve the interests of both parties'.<sup>43</sup> Although, within the development of centrally-funded medical services in the Highlands, there was little local objection to the principle involved, there was opposition, particularly in the early years, to the Board of Supervision which suffered from having significant influence in the strategic direction it set in the management of Scotland's poor law, but having little effective power to assert its authority, particularly in its often troubled relationship to Highland Parochial Boards. Later, tensions developed and persisted between general practitioners and the centre, produced by what appeared to them to be the overly bureaucratic infrastructure of the HIMS.

This thesis concludes that the Highlands and Islands Medical Service was essential to the improvement of medical services in the Highlands, that it raised the profile of conditions in the Highlands, but that it is not strictly accurate to refer to it as a 'forerunner of the National Health Service'. Its reliance throughout its development on local contributions meant it was still imbued with the ethos of self-help. It was however an important step in the normalisation of all aspects of medical services

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<sup>43</sup> Connor & Curtis, *Medicine in the Remote North*, p.4.

under centralised control, firstly under the Scottish Board of Health and then the Department of Health for Scotland, within the over-seeing eye of the Treasury. It contributed to the future state National Health Service and its establishment has been associated to the distinctiveness of the National Health Service in Scotland.

## CHAPTER ONE

### TOPOGRAPHY, ECONOMY AND SOCIETY: THE CONTEXT OF MEDICAL PROVISION IN THE HIGHLANDS

This chapter examines a range of social and economic conditions during the second half of the nineteenth century in the Highlands and Islands, within its diverse geographical context. It provides the framework for Chapter Two's examination of medical provision from the Scottish Poor Law Commission of 1843 to the 1880s. The unprecedented economic, social and demographic transformation of the nineteenth century ultimately changed the structure of society in Scotland. Rapid industrialisation and urbanisation, rising population growth and a series of depressions throughout the first half of the nineteenth century, placed increasing demands on an already pressurised system of poor relief and further intensified the differentials both between the Highlands and Lowlands and within the regions of the Highlands.

The physical environment of the Highlands and Islands had a major impact on the effective provision of medical services, which varied according to extensive physical variations in topography, climate and varying degrees of isolation. Evidence to the Napier Commission reported that on Harris some holdings were so small they had to be cropped continuously while 'other portions...are so rocky that we must carry soil on our backs before we can sow seed in it. ...The produce of our crofts could not maintain our family six months – in many cases not four months'.<sup>1</sup> The climate of the North-Western Highlands was a further obstacle to agriculture. The main characteristics were high winds, salt spray and excessive levels of rainfall. Sixty to one hundred and fifty inches of rain fell annually on the western Highlands, causing leaching of soil nutrients and loss of soil particles. The West Highlands were faced with rainfall twice as great as that of the central and eastern hills.<sup>2</sup>

Those circumstances affected both the ability of families to subsist and the difficulty of travel across often difficult terrain. 'Two broadly divergent social and economic systems' have been defined; 'farming society', located in the southern and eastern

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<sup>1</sup> *Evidence to the Napier Commission*, C.3980, 1884, Q.13116, p.846.

<sup>2</sup> P.A. Smithson, Regional Variations in the Synoptic Origin of Rainfall across Scotland, *Scottish Geographic Magazine*, 85, 1969, pp.157, 182.



Highlands and ‘a crofting region’ in the western mainland and islands.<sup>3</sup> Within that classification three demographic zones developed, distinguished by the consolidation of holdings in ‘Argyll, Highland Perthshire and the eastern parishes of Inverness’; crofting in the western coastal fringe and isles, and large sheep farms which were developed in the ‘central and western mainland’.<sup>4</sup> Those geographical and structural differences were an enduring feature throughout the remainder of the nineteenth and early twentieth centuries and the diverse levels of development which then occurred can be partly attributed to them. A greater dependence on cash earnings emerged in the farming areas as the subsistence society was eroded by increasing quantities of commodities imported from the industrialised lowlands. Levels of distress were much lower than the ‘persistent levels of acute destitution’ evident in the poorer society of the far west which clung to traditional methods of cultivation and subdivision.<sup>5</sup>

In the mid-nineteenth century the most important means of transportation within the Highlands were by road and sea; though early roads were basic and poorly constructed. ‘The fragility and decline which characterised the West Highland economy...retarded all aspects of locally funded development, particularly the construction of roads’.<sup>6</sup> The expansion of turnpike roads, ninety miles of ‘destitution’ roads which were constructed during the potato failures of the 1840s, drove roads developed throughout the north, west and central Highlands and innermost Hebrides and Wade roads, all increased communications within the Highlands, though varying in quality and random in location.<sup>7</sup> New landlords, using wealth from the profits of industrialisation and commerce in the South, contributed to road improvements. This was achieved in a number of ways; sometimes through involvement with local authorities, lending sums of money for specific schemes, which was then repaid, and by providing funding for road building with no recompense expected:

Occasionally, roads were largely built by landowners’ contributions, which were not expected to be repaid. In the case of the road to Auchnacloch in Strath Camoch, begun in 1848, Matheson of Ardrross (later Sir Alexander), agreed to pay £250 out of the estimated cost of £414, the rest to be paid by the 3rd district (Rosskeen, Kilmuir and Logie Easter). More usually, the

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<sup>3</sup> T.M. Devine, *The Great Highland Famine*, Edinburgh, 1988, p.1; M. Gray, *The Highland Economy, 1750-1850*, Edinburgh, 1988, p.2.

<sup>4</sup> T.M. Devine, *Clanship to Crofters’ War: the Social Transformation of the Scottish Highlands*, Manchester, 1994, pp.33-34.

<sup>5</sup> Devine, *Highland Famine*, p.2.

<sup>6</sup> Smith, unpublished PhD thesis, *The Development of Roads in the Northern Highlands*, p.6; Devine, *Highland Famine*, p.138.

<sup>7</sup> Devine, *Highland Famine*, p.138; O'Dell and Walton, *Highlands and Islands of Scotland*, p.200.

sum was repaid once funds became available, but without the usual interest.<sup>8</sup>

Road development was piecemeal and dependent on local circumstances and the ability of landowners to work together. In Lewis, the landowner, Sir James Matheson, spent £3,500 in the late 1840s having branch roads built.<sup>9</sup> By the 1860s, despite this investment, the high road round the island, though considered to be a great asset, was reported as being ‘deficient in bridges on the west of the island, several considerable streams being crossed by rough causeways’.<sup>10</sup> Sir William MacKinnon of Balnakill in Kintyre who owned the Strathaird estate in Skye, spent £2,500 completing the remaining three miles of road from Broadford to Elgol. By using local labour landowners were able to reduce tenant debt.<sup>11</sup> In other areas local rivalries prevented effective road development. Across regions, from the more affluent east to the west coast and islands of Ross and Cromarty, landlords were forced to work together, not always harmoniously and with implications for the safety of the people and their ability to reach medical help.<sup>12</sup> The estates of Lord Ashburton and MacLeod of Cadboll were wholly isolated by hills and torrents. The inhabitants of Assynt, which was ‘except for a few months in summer cut off from all connection with Dornoch ...had been compelled to “scramble along crags when the Kyle was in flood to reach a doctor, resulting in some fatalities”’.<sup>13</sup>

Though existing means of transport was utilised, such as the use of the mail-gig by passengers from the ferry from Kyleakin to Broadford, travel by foot was often the only alternative.<sup>14</sup> In 1889 crofters in Melness in Sutherland faced the expense of a ferry journey or a 12-mile walk to Tongue, in the absence of a road, which was not built till 1896. In a petition to the Sutherland estate they claimed ‘As the medical, postal, telegraphic & coach conveniences are all in Tongue, in weather when the Kyle

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<sup>8</sup> Smith, unpublished PhD thesis, *Development of Roads in the Northern Highlands*, p.223.

<sup>9</sup> M.M. MacIver, ‘A Social and Economic Survey of the Island of Lewis 1790-1850’, in *Transactions of the Gaelic Society of Inverness*, Vol. LII, 1980-82, p.271.

<sup>10</sup> Quote from A. Nicolson's *Report on the State of Education in the Hebrides*, PP XXV, 1867, p.12.

<sup>11</sup> ‘Construction was often undertaken by these landlords, using their tenants as labourers partly in order to allow them to work off rent arrears or arrears of road assessment they owed to the district trustees’, Smith, PhD, *Development of Roads in the Northern Highlands*, p.225.

<sup>12</sup> Smith, PhD, *Development of Roads in the Northern Highlands*, p.330.

<sup>13</sup> Smith, PhD, *Development of Roads in the Northern Highlands*, p.330, quoting the *Inverness Courier*, Sept 1827.

<sup>14</sup> *Report of the Poor Law Medical Services Commission*, p.164.

is stormy we are cut off from all these, & are in quite as bad a position as if we were in an island'.<sup>15</sup>

Local ferries and small hired boats were important for inter-island and mainland communications. On the islands, and in parishes divided by long inlets of the sea, ferry transportation was vital, particularly for smaller islands where the 'ferry' might be a rowing boat owned by a local. In 1833 one mail packet a week sailed to Stornoway from Poolewe, a situation which was improved by the development of steam shipping from the 1840s though sea transportation in many areas was still poor. The parish of Ballalan in Lewis, for example, was divided by an arm of the sea, giving it north and south sectors. Roads on the north side were adequate, but almost non-existent in the south, resulting in a journey from the south side of the parish of seven miles across moorland, as no proper ferry boat existed, a journey which would take a doctor many hours to travel. Many supplies were delivered by passing naval vessels, crucial to remote island communities such as St. Kilda.<sup>16</sup>

Small island communities had to fight to alleviate their isolation. Caledonian MacBrayne Ltd (Cal Mac), established in 1851, claimed they could not safely sail round the island of Soay, on the south side of the island of Skye, in the dark winter evenings as 'The island cannot be seen at night under the Coolin Hills'. Petitions to their Member of Parliament won the Soay islanders a mail supply boat of their own, which ran from Mallaig, but generally insular populations were 'at the mercy of the crofters' for the use of a small boat to travel to the doctor, or to transport the doctor to them. By the end of the century Cal Mac had taken over the main West Highland steamer routes, and for the larger islands, this became the most important form of communication.<sup>17</sup>

From the middle of the nineteenth century railroad construction penetrated north of the Highland line into the mainland Highland region till the last decade of the century when the rail network was consolidated. From mid-century, the Highland Railway ran from Perth to Inverness, though communications were hindered by single track

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<sup>15</sup> Quoted from National Library of Scotland (NLS), Acc.10225/150, petition to Duke (March 1889), in G. Baggott, *Melness Farm, Sutherland: The Land Question and the Congested Districts Board, c.1886-1911*, in *Journal of Scottish Historical Studies*, 30, p.2, 2010.

<sup>16</sup> *Report on the Social Condition of Lewis in 1901 as compared with twenty years ago*, 1902, Cd.1327, lxxxiii, p.287.

<sup>17</sup> L. Reed, *The Soay of our Forefathers*, c.1950, (no date of publication), Hampshire, p.62; *Dewar Evidence*, Q.12627, p.264.

sections till 1866.<sup>18</sup> From 1860 the railway extended westwards from Dingwall to Strome, reaching Kyle of Lochalsh in 1895.<sup>19</sup> Further south the railway extended from Fort William, reaching Mallaig in 1901 and in 1894 the West Highland line was developed from Helensburgh to Fort William. In 1897 the Skye line was extended to Kyle of Lochalsh and in 1900 the Highland Railway completed a direct line to Inverness from Aviemore.<sup>20</sup> The main benefits to the islanders of such improvements, were the conveyance of food and other vital supplies, such as medicines, to the nearest ports.

Variations in transportation, which lasted in some areas well into the twentieth century, meant that the journeys of doctors and nurses to their outlying patients were long, arduous, and often dangerous. A witness to the Dewar Enquiry noted ‘The country is rugged, roadless, and mountainous, and where not composed of islands is very largely peninsular on the seaboard, and inland is broken up by lakes and rivers’.<sup>21</sup>

Early in the twentieth century cars had provided the potential to significantly assist the provision of medical services. Initially however, motor transport was slow to penetrate the Highlands; cars were hindered by infrequent and poor quality roads and in many areas the bicycle or motor cycle was considered to be more practical. The advantages of motor transport were also in many cases outweighed by the cost of maintenance and risk of breakdown. In 1912 the running costs of a car were estimated to be £40 to £50 a year, before depreciation but in the parish of Farr in Caithness, the annual cost to the local doctor of running a car was £150, the poor quality of the roads requiring eight tyres in one year.<sup>22</sup> Many nurses used bicycles for the first part of their journey, which they would leave at the road end, the remainder of the journey completed on foot. (See Plates 1 & 2, Shetland nurses on bicycle and motorcycle, c.1930s.)

Parallel with gradual improvements in ground transportation there were developments in telegraphic and telephonic communications. The ability to call a doctor or nurse quickly in an emergency had obvious advantages in remote areas, where large

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<sup>18</sup> O'Dell and Walton. *Highlands and Islands of Scotland*, p.208.

<sup>19</sup> *Report on the Poor Law Medical Services*, 1904, Q.5185, p.178.

<sup>20</sup> C.E.R. Sherrington, *A Hundred Years of Inland Transport, 1830-1933*, London, 1934, p.142-3.

<sup>21</sup> Evidence from a number of witnesses to the Dewar Enquiry, quoted in the *Dewar Report*, section 2/13, Difficulties of Travel, 13, p.7.

<sup>22</sup> *Dewar Evidence*, Q.20197, p.404; Q.17706, p.369; Q.4420, p.111.

distances often separated doctor and patient. The telegraph and telephone were still relatively rare in the latter decades of the nineteenth century and although parish councils were entitled to government grants to establish a telegraphic service, they were unequally dispersed throughout the Highlands, with a gradual piecemeal increase over time.

In 1833 the only post office in Lewis was situated in Stornoway and by 1900 the number on the island had risen to nineteen.<sup>23</sup> The telegraph was introduced to the main branch in Stornoway in 1872 but there was no telegraphic communication with the country offices. In 1912 the county of Caithness had no telephone system, although in rural districts the use of railway telephones was sometimes permitted during emergencies.<sup>24</sup> The whole of the north and west of Skye had telephones for telegraphic work, with Dunvegan and Portree acting as exchanges.<sup>25</sup> Even when the telegraph was available it was vulnerable to cuts in service. Some of the smaller western islands were threatened with the withdrawal of their telegraphic facility by the post office. In South Uist, for example, the parish council was threatened with the withdrawal of the telegraph, following a dispute regarding the renewal of a seven year guarantee on the upkeep of the system, which cost about six pounds a year.<sup>26</sup> There were few telephones for public use. Where they were available, as in Scalpay in Harris and Eochar in South Uist, they had great potential to improve communications in rural areas, a potential which was not always realised as the telegraph was not generally accessible to the general population of those districts. Doctors were also not permitted to use the telegraph in certain areas, removing a significant opportunity for improved communications.<sup>27</sup> It was not till 1927 that Helmsdale in Sutherland had a trunk telephone exchange 'linking up Helmsdale by telephone with the outside world'.<sup>28</sup>

Further improvements in communications were facilitated by the Congested Districts Board. From its establishment in 1897 it helped in the opening of twenty-two telegraph offices, many of them on smaller islands, situated in:

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<sup>23</sup> *Report on the Social Condition of the People of Lewis*, 1902, p.li.

<sup>24</sup> *Dewar Evidence*, Q.4273, p.109.

<sup>25</sup> *Dewar Report*, p.14.

<sup>26</sup> *Dewar Evidence*, Q.14,132-14,137, p.294.

<sup>27</sup> *Dewar Evidence* Q.14553, p.303.

<sup>28</sup> The exchange was opened by Mr Andrew Lindsay, Golspie, convener of Sutherland and former member of the Dewar Committee, <http://www.helmsdale.org/old-stories1.html> (accessed April 2011)

**Table 1.1 Location of new telegraph offices 1897-1902**

- Argyll - Croggan, Mull, Balarlin, Tiree
- Inverness - Eriskay, S.Uist, six on Skye
- Ross - three on Lewis, three on mainland
- Sutherland - three
- Orkney - Eday, Orphir
- Zetland - Sandness, Vidlin<sup>29</sup>

**Source: Fourth Report of the Congested District Board for Scotland, Cd.1049, Vol. LXXXIII, p.xxxiv, 1902.**

By 1912 the Dewar Enquiry recorded that the majority of telegraphs in the mainland Highlands had been substituted by telephone exchanges, the only place requiring a significant extension being ‘Sutherlandshire, between Rosehall and Lochinvar’. The cost of installing new telegraph lines for telephones, estimated at c.£20-25 a mile, was considered to be prohibitive to many councils, but where telegraphic services were available, utilising the offices as telephone offices was suggested.<sup>30</sup> The benefits included quicker access to both doctors and nurses and also the ability for doctors to provide instructions to nurses by telephone or telegraph, when nurses were with patients in remote areas, ‘...places might be brought a good deal nearer by means of the telephone’. For example, the nurse in Fair Isle telegraphed the doctor in Lerwick for advice. Likewise, doctors receiving a telegraph or telephone call from a nurse knew that the call was genuinely urgent, which prevented unnecessary visits. Another advantage was the ability to prescribe ‘over the wire’, to enable patients to access medicines. Nurses could also alert the doctor to incidences of serious illness and the need for a visit, when the patient or family would not call the doctor.<sup>31</sup>

Despite faltering improvements in transportation and communication many, particularly in the west, still lived subsistence lifestyles, in uncompromising poverty. Poor housing conditions were endemic throughout the Highlands:

No general statement would adequately describe the various conditions under which this population exists. The circumstances of the crofters on the mainland or in Skye and Tiree differ from those to be found on the Long Island; and, even in the Long Island, a description of the crofter’s condition in the Lochs district of the

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<sup>29</sup> *Fourth Report of the Congested district Board for Scotland*, Cd.1049, Vol. LXXXIII, p.xxxiv, 1902.

<sup>30</sup> *Dewar Report*, pp.492-495. Evidence of Dr Magnus Maclean, Prof of Electrical Engineering at the Technical College, Glasgow, and a native of Skye, who was the final witness of the enquiry.

<sup>31</sup> Evidence of J. Patten MacDougall, Registrar-General for Scotland and Vice-Convenor of the County of Argyll and Miss Rumsey, Queen Victoria Jubilee Nurses Institute, to the Dewar Enquiry, pp.7, 32-34.

Lews, for example, would be inapplicable to South Uist, Barra, or other places.<sup>32</sup>

The Napier Report stated that ‘Among the various inconveniences which the people of the Highlands and Islands suffer...the one that strikes the stranger as the most deplorable...is the nature of their dwellings...It is difficult to say how far this is prejudicial to his happiness and welfare’.<sup>33</sup> By 1909 the Royal Commission on the Poor Laws in 1909 also reported that housing conditions in many parts of the Highlands were ‘grossly insanitary’.<sup>34</sup> At the end of the nineteenth century cattle housed with families was still widespread in some areas. Determined action by the Harris District Committee, in which legal action was taken against 28 households, did succeed in reducing the practice of housing cattle with people. A census of offenders in Harris had shown how widespread the problem was:

**Table 1.2 Numbers of Houses in Harris where the cattle were housed in the dwelling**

Jan. 1, 1896	167 houses containing	431 animals
Jan. 1, 1897	25       "       "	71       "
Jan. 1, 1898	13       "       "	23       "

**Source: J.P. Day, Public Administration in the Highlands and Islands of Scotland, London, 1918, p.300.**

In other parts of the Western Isles equally poor conditions were not so successfully dealt with. South Uist in 1896 still had 293 houses containing 854 animals, the inevitable insanitary conditions resulting in an epidemic of typhus fever during which, in four months, 19 deaths occurred.<sup>35</sup>

In 1888 deepest ‘poverty and dejection’ was recorded in the parishes of Lochs and Stornoway with cattle under the same roof and using the same door.<sup>36</sup> The poorest housing conditions were found in the Long Island, particularly Lewis, and in Shetland, where cattle housed with humans and serious levels of overcrowding was common till late in the nineteenth century. In 1897 the Report of the Local Government Board reported cases of thirteen people living in two small rooms ‘in one of which cooking was done, lines baited, fuel kept, and, in some houses, livestock

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<sup>32</sup> *Report of the Western Highlands and Islands Commission*, 1890, C. 6138, p.6.

<sup>33</sup> *Napier Commission*, Report, C.3980, 1884, p.48-49.

<sup>34</sup> *RC Poor Laws*, 1909, p.154.

<sup>35</sup> Day, *Public Administration in the Highlands*, p.300.

<sup>36</sup> *Dewar Evidence*, Q.5476, p.131; *Report on the Condition of the Cottar Population in the Lews*, C.5265, 1888, p.5.

in the shape of young pigs and hens'.<sup>37</sup> In 1911 the Census recorded that almost half the population in Shetland lived in houses with less than three windows, while the remaining four houses with no windows were also in those islands.

In evidence to the Royal Commission on the Poor Laws in 1909, the medical officer for the parish of Barvas in Lewis described conditions in the parish:

The number of inhabited houses is over 1300 grouped in some twenty-six separate townships; and over 1000 of these houses are glaringly and shockingly defective from a sanitary point of view, as regards their construction, internal arrangements, ventilation, lighting, drainage and surroundings. Human beings, cattle and other livestock are all housed under the same roof without any effective partition wall; all enter by the same door as a rule... Drainage is almost entirely neglected about the houses and liquid sewage is permitted to find its way where it may. The water-supply is often defective, and frequently contaminated with sewage... the task of attending to the medical wants of such a population is no light one...hitherto the agencies employed to cope with the difficulty have signally failed to effect any marked reform.<sup>38</sup>

This incriminating evidence was corroborated by the County Medical Inspector and by the General Superintendent of the Local Government Board who stated that they had also found housing of similar condition in other parishes.<sup>39</sup> Such conditions were seen as a public health problem, the authorities unable, 'without outside pecuniary assistance', to improve the existing conditions.<sup>40</sup> No bylaws existed to control the building of new houses 'Every man builds his house as he likes'.<sup>41</sup> Damp houses, low ceilings and lack of proper ventilation were the principal drawbacks. Local doctors noted the difficulty of treating pneumonia and rheumatic fever in such houses.<sup>42</sup>

By the second decade of the twentieth century some improvements were evident though there were significant variations throughout the Highlands. The Royal Commission on Housing reported that housing in Argyll, mainland Inverness and East Ross was relatively good, partly due to the greater availability of timber. However, 'at least 5000 defective houses in the Outer Islands' remained, with resultant insanitary conditions, the majority of which were on Lewis.<sup>43</sup> 467 black houses were enumerated in North Uist, and only 247 white houses. It was

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<sup>37</sup> Day, *Public Administration in the Highlands*, p.301.

<sup>38</sup> *RC Poor Laws*, 1909, Q.6588-9.

<sup>39</sup> *RC Poor Laws*, 1909, Appendix Vol. XXVIII, Report of visits to Poor Law and Charitable Institutions, etc.

<sup>40</sup> *RC Poor Laws*, 1909, pp.154-5.

<sup>41</sup> *Dewar Evidence*, Q.14571, p.303.

<sup>42</sup> *Dewar Evidence*, Q.4271, pp.48, 109.

<sup>43</sup> *Report of the Royal Commission on Housing*, 1917, p.440.



approximated that up to 80% of the housing in Lewis was black houses, and in Harris, 60 or 70%. It was noted that infectious diseases such as phthisis were easily spread in cramped accommodation, and containment of the disease was very difficult.<sup>44</sup>

In mainland Shetland, sanitary conditions were recorded as poor, most of the crofters' and cottars' houses not conforming to 'modern standards'.<sup>45</sup> Sites were ill-drained, walls and roofs poorly constructed and rooms ill-ventilated. Flooring was deficient and often absent entirely and overcrowding was common and in many villages sanitary provision usually absent, 'the surrounding ground greatly polluted by human excreta'.<sup>46</sup> As a result, in certain areas, such as Hamnavoe Sound and the docks, a form of typhoid fever was almost endemic, exacerbated by bad water supplies, which 'could be at once condemned were others available'. The only available water supply generally consisted of shallow wells, often polluted with surface drainage 'of a dangerous kind'. Only in Lerwick and Scalloway was the water supply considered satisfactory.<sup>47</sup>

Water supplies in the Hebrides were also unsatisfactory, water available from wells or surface streams described in 1891 as 'little better than cesspools for surface soakings'.<sup>48</sup> In the more populous areas of the Hebrides improvements in the water supply had been carried out, 'special districts' having been constituted. Wells were condemned, cleaned out, covered and fitted with pumps. However, districts with scattered populations were less fortunate, improvements in water supplies being in most cases beyond the proprietors' means. The medical officer visiting Lochs parish in the Lews in January 1888 observed widespread insanitary conditions and poor water supplies which caused typhoid fever and regular outbreaks of enteric fever. The most common diseases were anaemia, dyspepsia, ophthalmia tarsi and enteric fever. The prevalence of anaemia and ophthalmia tarsi was so great the doctor was unable to include figures for those ailments in a list of diseases prepared for the enquiry into conditions of the cottars in the Lews.<sup>49</sup>

By the beginning of the twentieth century, although there were still localised areas of poor sanitation and housing, rates of infant mortality (IM) in the seven Highland

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<sup>44</sup> *Report of the Royal Commission on Housing*, 1917, pp210-214.

<sup>45</sup> *Medical Officer of Health Report*, County of Zetland, Mainland District, 1920.

<sup>46</sup> *MOH Report*, Zetland (Mainland), 1920.

<sup>47</sup> *MOH Report*, Zetland (Mainland), 1920.

<sup>48</sup> Day, *Public Administration in the Highlands*, p.307.

<sup>49</sup> Evidence of Dr Roper, R.N., HMS Jackal, *Report on the Condition of Cottars in the Lews*, 1888, p.42.

counties of Orkney, Shetland, Ross and Cromarty, Argyll, Sutherland, Inverness and Perth were amongst the lowest in Scotland. The Highlands largely escaped the consequences of large-scale urbanisation; the overcrowding, poor sanitation and endemic infectious diseases prevalent in urban centres such as Glasgow and Dundee. Including the counties of Peebles and Bute, which represented the lowest rates in Scotland, the average IM rate was 67.2%, compared with an average rate for Scotland of 115%. Industrialised areas, such as Forfarshire and Lanarkshire, had rates of 139.5% and 129.2% respectively. The United Kingdom average in 1906 was 113%.<sup>50</sup>

Lower infant mortality rates masked high levels of uncertified deaths. While the non-Highland counties of Scotland rate of uncertified deaths was 1% (those which a doctor had not attended) the Medical Officer of Health for Inverness-shire estimated that 3967 deaths between 1890 and 1900 had taken place without a doctor being called; 400 in the parish of Kilmuir in Skye. An average of 22%, of all deaths in the Highland counties of Orkney, Shetland, Ross, Sutherland, Inverness and Argyll were uncertified, masking an even higher rate of 38%, in Shetland.<sup>51</sup> Lack of cash prohibited the payment of doctors' fees.

The famine of the 1840s had reduced the dominance of the potato in the Highland diet and areas within the Highlands became less self-sufficient and were forced to rely more heavily on alternative foodstuffs, such as meal, delivered by steamers and other shipping from the south. Foodstuffs stored for animals, such as turnips and oats intended for seed, were made available to those in need. Those close to the coast also benefitted from proximity to fish.<sup>52</sup> Though the potato remained a significant item, as the nineteenth century progressed the diet of the Highland population altered. Potatoes, herring, milk and oatmeal still constituted the main input of most peoples' diet, but in addition other items such as tea, sugar, refined flour, bacon, cheese and butter were gradually added. Those additions to the staple diet did not automatically mean that the Highlanders' diet was healthier, consisting as it did of mainly of starchy, sweet and refined foods and a deterioration in dental health was evident by the 1940s.<sup>53</sup> Diseases of the heart and circulatory system, which in the 1860s caused

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<sup>50</sup> H.M. Blagg, *Statistical analysis of infant mortality and its causes in the United Kingdom*, London, 1910, p.33.

<sup>51</sup> *Report on Poor Law Medical Relief*, 1904, pp.71-72.

<sup>52</sup> Reports by officers sent to Distressed Districts, Appendix B, No 3, *Second Report of the Annual Report of the Board of Supervision*, p.18.

<sup>53</sup> King, Dental Disease in the Island of Lewis, *Special Report Series, Medical Research Council*, 241, London, 1940.

less than 5% of all deaths had risen to 22.3%, by the 1930s and the incidence of cancer also rose.<sup>54</sup> As Smout has noted, this followed the pattern of diet in the industrialised sectors of the country, and is a strong indicator of increasing standards of living.<sup>55</sup>

There was of course, great variation in diet within the Highlands. In Southern Argyllshire and Highland Perthshire, eastern Inverness-shire and parts of Ross, a more varied diet had evolved from the early eighteenth century. Potatoes were still an important element of the diet, but grain was 'either as significant or even more important in the structure of production and consumption'.<sup>56</sup> The following items which were imported by steamer to Lewis in 1884 illustrate both the increasing diversity in diet and the growing reliance on imported food:

**Table 1.3 Steamer imports to Lewis 1884**

<b>Tea-</b>	109 chests
	539 half-chests
	230 quarter-chests
<b>Oatmeal-</b>	15,474 bolls of 140lbs.
<b>Cheese-</b>	17 tons
<b>Bacon-</b>	10 tons
<b>Butter-</b>	60 tons
<b>Flour-</b>	15,814 bolls <sup>57</sup>

**Source: Report on the Condition of the Cottar Population in the Lews, 1888, p.48.**

To this should be added one-eighth of the above for imports by other steamers.<sup>58</sup> The medical officer for Unst, in Shetland, reported an almost completely vegetable diet and that though poultry and pigs were kept they were seldom eaten, instead sold for cash or bartered.<sup>59</sup> Eggs, also seldom eaten, were also bartered for tea, sugar, tobacco and paraffin. A scarcity of milk was reported in North Harris, the population living on scones and tea, salt mackerel, herring and potatoes for eight months of the year.<sup>60</sup>

Those areas with the greatest reliance on seasonal earnings were badly hit and the

<sup>54</sup> Flinn, *Scottish Population History*, Cambridge, 1977, p.386.

<sup>55</sup> T.C. Smout, *A Century of the Scottish People, 1830-1950*, 1986, p.80.

<sup>56</sup> Devine, *Highland Famine*, p.2.

<sup>57</sup> In addition it was estimated that an additional one-eighth could be added from other steamers.

<sup>58</sup> *Report on the Condition of the Cottar Population in the Lews, 1888*, p.48.

<sup>59</sup> *Napier Commission Evidence*, Many crofters and other witnesses, including doctors, reported the widespread practice of selling eggs for cash income, with very few being eaten locally. See, for example, the evidence of the surgeon of Gesto Hospital, Skye and other witnesses at Q.3829, p.198 and Q.7563, p.434; *Dewar Evidence*, Q.7251, p.160.

<sup>60</sup> *Dewar Evidence*, Q.13101, p.274.

1888 enquiry into the condition of the cottar population found ‘deepest poverty and dejection’, with a high reliance on destitution meal. Entries of the house-to-house visitation recorded situations such as ‘No stock.-- Eat the cow long ago. Has some potatoes still; has got some destitution meal...’<sup>61</sup>

A typical daily menu of a crofter in Shetland would be, a breakfast of porridge and milk, lunch for the school children consisting of cocoa and bread (in the winter supplied by public subscription). Dinner was mainly potatoes and vegetables, or a broth made with barley and rice. Porridge consumption had declined slightly due to the availability of fresh bread.<sup>62</sup> The increased consumption of refined carbohydrates, such as white bread and tea, was reputed to lower constitutions as it provided fewer vitamins to fight disease.<sup>63</sup>

Within this context of inclement physical conditions, poor communications, scattered remote communities, inferior housing conditions and diet, doctors and nurses in the Highlands and Islands carried out their demanding and often arduous duties. They struggled too with low salaries while payment of private fee income was unpredictable. The communities they were charged to attend were, at the end of the nineteenth century, still based on a partially subsistence existence which affected levels of health and wellbeing.

The physical factors which determined land use, employment opportunities and quality of life were equally barriers to economic and social wellbeing over which the population had little control.<sup>64</sup> Despite all this, a witness to the Dewar Enquiry commented in 1912 ‘I am surprised that many of them see so much elsewhere and come back to live in this country.’<sup>65</sup> As Smout noted, the life of a crofter was difficult, but the direct attachment to the land was long-term and enduring, and while employment opportunities existed many chose to remain in the Highlands.<sup>66</sup>

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<sup>61</sup> *Report on the Condition of Cottars in the Lews*, 1888, p.5, 9.

<sup>62</sup> *Dewar Evidence*, Q.7251, p.160.

<sup>63</sup> Paton & Findlay, Poverty, Nutrition and Growth, Report by Technical Commission on Nutrition, *Bulletin Special Report Series*, Medical Research Council, No. 101, 1926.

<sup>64</sup> The physical geography of the Highlands has been studied by geographers and historians, including Darling who produced the *West Highland Survey*, 1955. Other works include Collier, *The Crofting Problem*, 1953; O'Dell and Walton, *The Highlands and Islands of Scotland*, 1962 and Day, *Public Administration in the Highlands and Islands of Scotland*, 1918.

<sup>65</sup> *Dewar Evidence*, Q.11095, p.234.

<sup>66</sup> Smout, *A Century of the Scottish People*, 1986, p.66.

## CHAPTER TWO

### THE FOUNDATIONS OF MEDICAL PROVISION IN THE HIGHLANDS AND ISLANDS, 1843-c.1880

Within the context of the economic and social conditions outlined previously this chapter will examine the development of medical services and public policy in the Highlands from the reform of the Old Poor Law in 1843, which led to the first government-funded poor law medical service in Scotland – and established the development of the Medical Relief Grant (MRG) in 1848 – to the 1880s. From that decade the rise of the public health service and county government reflected a changing political environment which culminated in the Liberal reforms; the Dewar enquiry was one of the final reforms to be undertaken. Those issues will be the main focus of Chapter Three.

#### 2.1 The Old Scottish Poor Law: pressure for change

In the mid nineteenth century Scotland's economy and infrastructure was in the process of adjusting to the stresses placed on it by rapid industrialisation and urbanisation. Significant regional variations had polarised 'an enormous gulf in development and wealth between the Highlands and the Lowlands, with a particular zone of economic under-development along the western Highland coast'.<sup>1</sup> In addition to the economic and social diversity between the Highlands and Lowlands, the disparity in the economic conditions in the Highland counties – large areas of the north and west were still reliant on a subsistence economy – also influenced the nature and scale of medical assistance available in each region.

During this period, although improvements in the conditions faced by doctors were faltering, a number of institutional, governmental, societal and economic changes occurred which provided the administrative foundations and governmental and public acceptance of the need for wider and more profound developments in the twentieth century. Much of the primary evidence supporting this view is in the evidence of the numerous parliamentary enquiries that were established during this period.

As the nineteenth century progressed, concern grew within sections of Scottish society regarding the effectiveness of the Old Poor Law, which struggled to meet the

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<sup>1</sup> I. Levitt and T.C. Smout, *The State of the Scottish Working Class in 1843*, p.10.

demands of mounting levels of pauperization.<sup>2</sup> Voluntary assessments and increases in rates were introduced to meet the growing demands placed on poor relief expenditure. However, the growing prospect of legal assessment caused widespread consternation. A recurrent theme of two reports on the Scottish Poor Law by the General Assembly of the Church of Scotland, in 1818 and 1839, was ‘the evils of legal assessment’, arguing that its introduction would cause the numbers of paupers to rise, ‘moral restraint’ having been removed.<sup>3</sup> The self-help ethos was clearly still strongly imbued within the Church of Scotland.

One of the major voices calling for change to the existing system of poor relief in the mid nineteenth century was the medical profession, which was concerned about the level and quality of relief available to the sick poor and also about the charitable premise within which poor relief was provided. Led by Dr William Pulteney Alison<sup>4</sup>, Professor of Medicine at Edinburgh University, who articulated the concerns to the enquiry, the medical profession attacked the premise of moral failure. They supported the view that disease was spread by contact among the poor (contagion theory) and contested the belief, current at the time – and supported by Edwin Chadwick – that disease was transferred through the air (miasma theory). They called for greater levels of government intervention in the lives of the poor and argued strongly that the real cause of the condition of the poor was inadequate diet, housing and destitution and that non-registered poor should have a right to relief to prevent poverty and ill health. Others, including Thomas Chalmers, with whom Professor Alison debated in writing, and the majority of the Commissioners, continued to argue that a right to relief would promote indigence and inhibit self-improvement.<sup>5</sup> During the outbreaks of cholera and other epidemic fevers during the first half of the nineteenth century, which had also affected the middle classes, Alison had pressed the connection between destitution and fever, which strained an already ailing system of poor relief. Further demands on

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<sup>2</sup> The plight of the hand loom weavers in Paisley provides an excellent example of the growing pressures on poor relief, where during 1841 those seeking relief grew from 2,000 to almost 15,000. Edward Twistleton, a civil servant and later to be a Poor Law Commissioner on the 1843 enquiry, was sent by the government to provide aid to Paisley during the crisis, though in a covert manner which would not set a precedent for the government. T.C. Smout, ‘The Strange Intervention of Edward Twistleton: Paisley in Depression, 1841-3’, in T.C. Smout (ed.), *The Search for Wealth and Stability*, 1979, p.226.

<sup>3</sup> Cage, *Scottish Poor Law*, pp.112-114.

<sup>4</sup> Prof W.P. Alison had a long history in campaigning for improvements in system of poor relief. He was a leading member of the Association for obtaining an Official Enquiry into Pauperism in Scotland, formed in 1840 and in that year also was author of *Observations on the Management of the Poor in Scotland and its effects on the Health of the Great Towns*; See also L.S. Jacyna, William Pulteney Alison (1790–1859), *Oxford Dictionary of National Biography*, 2004.

<sup>5</sup> Day, *Public Administration in the Highlands*, p.91; Levitt and Smout, *State of the Scottish Working Class*, p.217.

poor funds followed the Disruption of 1843, which seriously reduced church door collections. As the burden of the poor law on the middle classes increased, their financial concerns were matched by raised awareness of their vulnerability to disease.

## **2.2 The Poor Law Enquiry 1843-45**

In 1843 the Poor Law enquiry investigated the ‘practical operation’ of the poor law and how it might be amended.<sup>6</sup> It assembled wide-ranging data on many aspects of working-class life, including unemployment, prices, wages, prudence and indigence, diet and vitally, for the purposes of this research, medical relief. The report and evidence revealed the extent of poverty and destitution evident throughout Scotland, and the paucity of medical assistance for the poor sick. The enquiry gathered detailed data on the sources of parish poor law income, which came from four main sources; assessment, both legal and voluntary, voluntary contributions, church-door collections and mortifications – the hire fee for a black cloth to cover a coffin. The report, published in 1844, stated, ‘there is scarcely any provision made for medical relief to the poor out of the poors funds in Scotland. This seems to be left systematically to private charity’.<sup>7</sup> Prior to 1845 the poor were largely reliant on the charity of those doctors that existed, both for medicines and attendance.<sup>8</sup> Parishes, supported by landowners and other random local sources of funding, provided relief to the poor in the form of food, clothing or money – much of it below the level of subsistence – and offered limited medical or surgical expenses.

In the Highlands, large overpopulated parishes and low levels of income made the operation of the Poor Law even more inadequate. ‘...on Barra, Harris and South Uist, for example, the community was so poor and the heritors so concerned about encouraging emigration, that they did not bother about having a poor roll at all.’<sup>9</sup> Expenditure per pauper in Highland parishes in the early nineteenth century was the lowest in Scotland; levels of support largely dependent on the varying ability of parish councils to generate parochial funds. In some eastern and southern areas of the Highlands, where cash transactions formed a greater proportion of the economy, higher allowances were made, while evidence to the enquiry recorded the lowest poor

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<sup>6</sup> *Report from Her Majesty's commissioners for inquiring into the administration and practical operation of the Poor Laws in Scotland*, Edinburgh, [557], 1844.

<sup>7</sup> *Report of the Departmental Committee enquiry into the system of Poor Law Medical Relief and Management of Poorhouses*, 1904, Cd. 2008, Vol. 1, Part III, p.4.

<sup>8</sup> Report into the system of *Poor Law Medical Relief*, 1904, Vol. 1, Part III, p.4.

<sup>9</sup> Levitt and Smout, *The State of the Scottish Working Class*, p.180.

law incomes in the north and west Highland parishes and Shetland. Throughout Scotland a very small proportion of poor law income contributed to the salaries of doctors; a national average of 3<sup>3</sup>/<sub>4</sub>d per pauper per annum, with many Highland parishes paying virtually nothing.<sup>10</sup> In 1800 annual sums paid to paupers in the Highlands ranged from £1 10s in Argyll to 16s in Ross, Sutherland and Caithness. Comparative figures in the Lowlands varied from £5 15s in Merse and Teviotdale, where expenditure per pauper was the highest in Scotland, to £2 2/- in Aberdeen.<sup>11</sup> By 1842 the situation was little changed; data submitted to the enquiry recorded parish poor law expenditure in the north and west highlands ranging from of £0.19 per recipient in Skye and the Outer Hebrides to £0.81 in North Argyll compared with £2.64 to £3.85 in East Lothian and the Borders.<sup>12</sup> Landlord absenteeism also contributed to lower levels of parish funds.<sup>13</sup> For example, in 1817, the minister of Knapdale, Argyll, reported that nine out of ten non-resident landlords, with a gross rental of £4,000 contributed nothing to relief. Some landlords were more responsible; in 1843 the Lewis estate paid a salary of £20 to Dr Roderick Millar, the assistant medical practitioner in Stornoway.<sup>14</sup> In that year fewer than half the Highland parishes provided medical relief to those receiving poor relief.

The Poor Law (Scotland Act) 1845 brought in two major developments, recommended by the report, which changed the public face of the Poor Law in Scotland. They were the establishment of a central Board of Supervision and the transfer of responsibility for the registered poor from the Church of Scotland to Parochial Boards, which came under the authority of the newly established Board. The Board, whose members gave their services on a voluntary basis, formed ‘the first central poor law authority in Scotland’.<sup>15</sup> Based in Edinburgh and responsible for the supervision and enforcement of the locally devolved administration of the parochial boards, the Board of Supervision could not issue Orders and was essentially a national advisory and conciliatory body, but with the power to issue regulations, which if approved by the Secretary of State became obligatory. The Board reported to the

<sup>10</sup> Levitt and Smout, *The State of the Scottish Working Class*, pp.217, 264.

<sup>11</sup> R. Mitchison, *The Old Poor Law in Scotland*, Edinburgh, 2000., pp.139, 189; Cage, *Scottish Poor Law*, p. 36.

<sup>12</sup> Levitt and Smout, *State of the Scottish Working Class*, pp.202-203.

<sup>13</sup> R.A. Cage, *The Scottish Poor Law 1745–1845*, Edinburgh, 1981, pp.35-36.

<sup>14</sup> Stornoway Historical Society -The Early Medical Men of Lewis 1700-1918, [www.stornowayhistoricalsociety.org.uk/](http://www.stornowayhistoricalsociety.org.uk/) (accessed April 2010) A teacher at that time in Shetland would have a salary of c£15-18; [http://shetlopedia.com/Teachers\\_of\\_Shetland\\_1771\\_-\\_1852](http://shetlopedia.com/Teachers_of_Shetland_1771_-_1852) (Accessed Feb 2011) I am grateful to John Randall of The Islands Book Trust, for this information.

<sup>15</sup> Cage, *Scottish Poor Law*, p.147.



Secretary of State for Scotland bi-annually, detailing the numbers and condition of the poor and the amount spent on poor relief.<sup>16</sup> The importance of the role of the Board in the increase in medical provision throughout the century, and the rigorous nature of its monitoring is documented in its annual reports and in Medical Officer of Health reports.<sup>17</sup>

The first Chair of the Board, Sir John McNeill, a Tory, was influential in those developments. Originating from Colonsay, and well-connected socially, he was a doctor, providing the Board with expert knowledge. Though his influence was considerable, Blackden considers his appointment to have limited the source of medical advice to the Board, which preferred 'at least in theory, a more flexible approach and to choose expert opinion from the profession as a whole'.<sup>18</sup> He was, nevertheless, a forceful character. During the Highland famine, from February to April 1851 he personally carried out an investigation on the condition of 27 parishes in the Western Highlands, his meetings with parishioners undoubtedly helped by his fluency in Gaelic. The purpose of the enquiry was to determine the level of distress amongst the people there and seek methods to relieve it. His report was presented to the Board of Supervision in July of that year. It detailed high levels of population density, caused by prolific subdivision and a lack of local employment. Though expressing sympathy for the evidence of distress he met, he documented the 'prejudicial effect [of eleemosynary aid] on the character and habits of the people...the fact is unquestionable, that a people who some years ago carefully concealed their poverty, have learned to parade, and of course, to exaggerate it' His solution to the conditions he encountered was to encourage widespread emigration; he supported the Highland Emigration Society, which in the five years following his report transported almost five thousand people from the Western Highlands and Islands to Australia.<sup>19</sup>

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<sup>16</sup> The Board comprised the Chair, Sir John McNeill, three county sheriffs, the Lord Provosts of Glasgow and Edinburgh, the Solicitor General and two crown appointees, Levitt, *Poverty and Welfare in Scotland*, Edinburgh, p.8.

<sup>17</sup> Cage, *Scottish Poor Law*, p.147-150; Blackden, *Board of Supervision*, p.151; The Annual Reports of the Board of Supervision were produced from 1845 till 1894, when the duties of the Board were taken over by the Local Government Board for Scotland; Medical Officer of Health reports were prepared by County Medical Officers of Health and by their local counterparts. They are vital sources for the study of the implementation of Public Health Policy.

<sup>18</sup> Blackden, *Board of Supervision*, p.157.

<sup>19</sup> *Report to the Board of Supervision by Sir John McNeill, G.C.B., on the western highlands and islands, 1851.*

During the 1860s poor relief was increasingly seen as too lenient and following the end of Sir John McNeill's chairmanship, his replacement by his nephew Malcolm McNeill, encouraged a more stringent attitude to poor relief. A Parliamentary Select Committee on the Poor Law Scotland, established in 1869, advocated revisions on what form relief would take and who eligibility criteria, attempting to define 'adequate relief'.<sup>20</sup>

Although the Board of Supervision had centralised control, at a local level considerable power was vested in the parochial boards which had the power to raise poor funds by assessment, which then became an annual charge.<sup>21</sup> It was a double-edged sword, given the pecuniary difficulties some parishes faced. The ability to raise funds annually by assessment represented the prospect of increased income to the parochial board but represented a greater financial burden to the people. A further amendment in 1861 halved the assessment between the heritors and the tenants within each parish. Cases were still rigorously examined and adjudicated upon. For example, in 1866 William Pearson from North Mavine in Shetland, whose leg had been amputated, with a wife and four children, was refused poor relief, a decision which was upheld by the court on his appeal. Similarly, a widow with three children residing in Bressay, was also refused relief.<sup>22</sup>

As economic conditions worsened from the 1870s, the ability to collect due rates in poorer parishes declined, as public enquiries investigating rates arrears revealed in later years.<sup>23</sup> Parochial boards were required under the Act to compile a list of registered poor and appoint a Poor Law Inspector. The Act also gave paupers the right of appeal to the Board. The composition of parochial boards varied; non-assessed parishes continued to be administered by the kirk session and heritors, while assessed parishes also contained individuals elected by the ratepayers. Over time, the maintenance and effectiveness of the new administrations varied throughout localities, progress largely influenced by the individuals in charge whose attitudes shaped local politics. Evidence to the Napier Committee reported the approval of the Board of Supervision for a joint appointment of Poor Law Inspector for the parishes of Barvas,

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<sup>20</sup> Levitt, *Poverty and Welfare*, pp.16-17.

<sup>21</sup> *Report into the system of Poor Law Medical Relief, (Report on Poor Law Medical Relief, 1904)* Vol. 1, Part 111, Cd. 2008, 1904; Cage, *Scottish Poor Law*, p.148-9.

<sup>22</sup> *The Poor Law Magazine*, 1865; Report of Sheriff Court of Zetland, 1865-6, pp.456-7.

<sup>23</sup> *Reports to the LGB for Scotland on the Burden of the Existing Rates and the General Financial Position of the Outer Hebrides*, Cd. 3014, 1906.

Lochs and Uig on a salary of £25. The inspector promptly had his salary raised to £50, to cover all three parishes. As he was not living in any one of the parishes it was considered by the local minister of Barvas that ‘those on the roll [were] not properly attended to, and the new applications [were] not faithfully and properly considered’. He also believed that the rates were unduly high as a result of the administrative inefficiencies.<sup>24</sup>

Despite the administrative changes outlined above, the Poor Law Act was criticised for not fundamentally changing the existing system of poor relief. The principal evidence of conformity to the existing *status quo* was that no attempt was made to extend those eligible for relief. One of the Commissioners, Edward Twistleton, civil servant and former English Assistant Poor Law Inspector, who was sent to be in charge of the Paisley intervention in 1841, produced a separate dissenting report pressing for, among other things, a national compulsory assessment, ‘that medical relief should be supplied more extensively to the poor, and that this should form a proper charge upon the poor funds’. He also criticised the decision to leave the supply of medical relief to each parish – each of which was empowered ‘to adopt their own scheme of relief, since...what works well in one parish may be very ill suited to another.’ – stating that ‘to leave the arrangements exclusively in the hands of the parochial boards would almost inevitably...result in the remuneration of medical officers being fixed at a lower rate than was adequate for the services they might be called on to perform, or perhaps being called on to attend to the sick gratuitously...’<sup>25</sup> In Highland parishes, where doctors’ remuneration was already vulnerable to non-payment; the new legislation did not offer any immediate improvement.

Nevertheless, for the first time provisions were made for medical relief to paupers, the cost to be a charge on the paupers’ fund. The medical clauses of the 1845 Act included, firstly, that parishes containing a poorhouse were required to appoint at a reasonable salary a properly qualified medical officer to attend sick and infirm inmates. Parishes, or combinations of, with a population greater than 5,000, also had the authority to erect a poorhouse. Secondly, parishes were required to provide out of their funds medicines, medical attendance, a nutritious diet and clothing for the sick poor and

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<sup>24</sup> *Evidence to the Napier Commission*, Vol. 11, C.3980, 1884, pp.9978-9.

<sup>25</sup> *Report into the system of Poor Law Medical Relief*, Volume 1, Part 111/1/11-12, Cd. 2008, 1904; *Report of the Royal Commission on the Poor Laws, Report of Scotland*, 1909, p.192; Smout, *The Strange Intervention of Edward Twistleton*, p.231.

thirdly, that parochial boards could subscribe to charitable medical institutions out of their funds.<sup>26</sup> Of particular relevance to the Highlands, the extent of outdoor aid was not specified. It was to be given ‘in such manner as might be found practicable and might be considered most expedient and equitable in the circumstances of each parish’.<sup>27</sup>

Parishes were not necessarily obliged to appoint a parish medical officer for the outdoor poor. To meet the requirements of the act joint arrangements to provide medical attendance by a doctor from a neighbouring parish could be arranged. An attempt to make the appointment of a medical officer in each parish compulsory, failed on the grounds that it would not be practical in remote Highland parishes with scattered populations. The circumstances, therefore, which hindered the provision of basic medical relief, were used also as a justification for not improving the situation by statutory means.

Despite evidence of changing attitudes to destitution and pressure from the medical profession the 1845 act, therefore, only changed the ‘shape of the system’, the basic values and beliefs of the establishment regarding poor relief remained unchanged. Improvements in the care of the poor were brought about by the crucial role of private charity, which compensated for the lack of legal provision.<sup>28</sup> Nevertheless, although medical relief provided by the 1845 act was considered to be deficient and its legislative powers initially permissive, it was important in establishing a statutory base on which further improvements could be built and was an important step in the development of public health policy.

### **2.3 Population and location: factors hindering change**

The effectiveness of health, welfare and medical services in the Highlands were influenced also by tradition and by changing demographic and geographical factors. In the far west and outer isles, dependence on the potato and its ability to sustain large numbers on intensely subdivided land, reflected the enduring attachment of the crofting population to the land, factors which led to resistance against emigration and

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<sup>26</sup> Minute of the Board of Supervision, Feb.2,1848. Quoted in *Report on the Poor Laws*, Appendix LXI, p.275.

<sup>27</sup> Blackden, *Board of Supervision*, p.151.

<sup>28</sup> For a comprehensive coverage of the origins of the end of the Old Poor Law and the subsequent establishment of sick relief, see Cage, *Scottish Poor Law*, Chapter 7, and Levitt and Smout, *State of the Scottish Working Class*, Chapters 8 and 9.

which encouraged population growth.<sup>29</sup> Despite this, the famine of the 1840s precipitated the mass emigration of large sections of the Highlands, a process that was ongoing from the early decades of the century, which became intensified in the immediate aftermath of the famine and which ‘continued intermittently throughout the second half of the nineteenth century’ with significant demographic consequences.<sup>30</sup>

One of the demographic consequences of sustained emigration, according to Flinn, was a reduction in the rate of natural increase by a slowing down of the rate of marriage. More single adult males emigrated from the Highlands than women, resulting in an imbalance of men and women of marriageable age. Women consequently married and had children later than in other Scottish counties, though fertility levels were not considered to be affected by the later age of marriage. In 1911 4.1% of males of age 20-24 and 21.7% of those aged 25-29 were married in the Highland Counties, compared with 14.1% and 47% respectively in the Western Lowlands.<sup>31</sup>

Devine has identified regional variations within the population loss from the Highlands. Population rates did not universally decrease; the parishes of the Outer Isles experiencing increasing population levels until the early twentieth century, sustained by income from seasonal migration and continued subdivision of available land.<sup>32</sup> By the first decade of the twentieth century however, population levels were falling in all areas of the Highlands. The 1901 census recorded 8.3% of the population of Scotland living in the Far North (2.0%) and Highland Counties (6.3%); in the 1911 census those totals had dropped to 7.6% (1.8% and 5.8% respectively).<sup>33</sup> Those figures also contain considerable regional and local differences between, for example, the more affluent county of Argyll, with its proximity to lowland markets and commerce and the more remote areas of Ross and Cromarty and the Outer Isles.

A related demographic factor which had significant consequences for medical services was the aging of the population, attributed in the Highlands by Flinn mainly to the high rates of emigration of young men and the movement to the industrial

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<sup>29</sup> See Flinn, *Scottish Population History*, Chapter 7, The Demographic influence of the potato, pp.421-438 and Devine, *The Great Famine*, pp.288-296. The report and evidence of the Napier Commission and many other government enquires at the end of the nineteenth century document the expansion of subdivision in the far west and outer isles.

<sup>30</sup> Flinn, *Scottish Population History*, p.438.

<sup>31</sup> Flinn, *Scottish Population History*, p.324.

<sup>32</sup> Devine, *The Highland Famine*, p.288-294.

<sup>33</sup> Flinn, *Scottish Population History*, p.306.

centres of the central belt.<sup>34</sup> The Poor Law enquiry, published in 1909, recorded that in 1901 the five Scottish counties with the highest proportion of persons over 60 years of age were in the Highlands (See Table 2.1). The report attributed the aging of the population to young men seeking out the greater and more affluent employment opportunities of the industrialised central belt and richer agricultural districts. It is likely that both factors led to the preponderance of older age cohorts within the population. The Highland figures can be contrasted with the industrial heartlands of the central belt, where the proportion of persons over 60 was significantly lower.

**Table 2.1 Scottish Counties with number of persons greater than 60 per 1000 of population in 1901**

Counties	Per 1000 of population 1901
Zetland	161.3
Sutherland	157.9
Orkney	152.9
Caithness	143.2
Ross and Cromarty	134.1
Lanark	52.3

**Source: Royal Commission on the Poor Laws and Relief of Distress, 1909, Cd. 4922, Part 11, p.10.**

For those who remained in the Highlands poor relief was often the only means of assistance in old age. Although industrial areas had high levels of pauperism they contained more centrally located poorhouses, which put less strain on outdoor relief. For example, Lanarkshire, though having a low proportion of aged population, had a relatively high rate of aged pauperism of 111.6 per 1000 of the aged population, the comparative figures in the Highlands included Sutherland (141.5%), Inverness (125.0%), Ross and Cromarty (123.9%) and Zetland (109.6%). However, while Lanarkshire had a ratio of 3.6 outdoor paupers to one indoor pauper, Sutherland had 31.6 outdoor paupers to one indoor pauper. Such a large proportion of outdoor poor placed a significant additional responsibility on the poor rate and on parish medical officers.<sup>35</sup> Most rural areas had few poorhouses and many were remote from the population of the parishes, to which they belonged, resulting in Highland areas to considerable resistance to the poorhouse.

<sup>34</sup> Flinn, *Scottish Population History*, p.321.

<sup>35</sup> *Royal Commission on the Poor Laws and Relief of Distress*, 1909, Cd.4922, Part II, p.10-11.

The parishes in the west of Sutherland are from fifty to seventy miles from the railway station, and about ninety from the poorhouse. The parishes of Harris, South Uist and Barra, in the Long Island Poorhouse Combination, have to send their paupers by sea, and a very rough passage it is at certain times of the year. A poorhouse, to be of value, should be available at any time and should not be too far distant, so that friends might have an opportunity of visiting the inmates.<sup>36</sup>

The committee noted that in the Highlands ‘the difficulty in dealing with such cases is very great, and the suffering which the poor endure rather than avail themselves of the comparative comfort of the poorhouse is great’.<sup>37</sup> The consequence was that the paupers had to be provided with relief at home. Some parishes took the step of re-building paupers’ houses or of building new houses for the poor, which were charged to the rates. For example, in Harris the council built 13 new black houses at a cost of £20-24 each and repaired and maintained a further 27 houses for this purpose. The alternative was shipping paupers to the Combination Poorhouse in Lochmaddy in North Uist, to which there was great resistance.<sup>38</sup>

Newly appointed Inspectors of the Poor were responsible for monitoring and visiting the registered poor in their homes and providing medical aid in the event of sickness. However, while it was a statutory requirement to appoint a doctor to a poorhouse, there was no such obligation to provide for the outdoor poor. Edward Twistleton’s concern was vindicated: ‘Where regular medical attendance, as in a poorhouse, was made compulsory, the medical relief was on the whole adequate; where the detailed arrangements were left entirely to the local bodies it was, as a rule, inadequate.’<sup>39</sup>

## **2.4 The Medical Relief Grant 1848**

In the first years of the operation of the act, spending on poor law medical relief throughout Scotland remained modest. Between May 1847 and May 1848 the amount spent on parochial medical relief throughout Scotland rose from £4,055 to £12,879, an increase of almost £9,000. The rise in expenditure was attributed largely to the impact of epidemics of fever in 1847 and cholera in 1848 and also to aspects of the

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<sup>36</sup> *RC Poor Law*, 1909, Evidence from Mr Miller, General Superintendent of Poor, 54395 (12). Quoted in *RC Poor Law*, 1909, Cd. 4922, Part III, p.89.

<sup>37</sup> *RC Poor Law*, 1909, Part III, p.121.

<sup>38</sup> *Report on the burden of rates and the general financial position of the Outer Hebrides*, Cd. 3014, 1906, p.xxi.

<sup>39</sup> *Report on Poor Law Medical Relief*, 1904, Vol. 1, section 4, p.5.

classification as to what constituted medical relief; till 1848 the provision of cordials and special diet was classed as medical relief, and after that year maintenance.<sup>40</sup>

Despite the increase it represented a small proportion of poor relief expenditure under the Poor Law; during the year ending May 1847 a total of £433, 915 had been spent on 146,370 paupers, representing 17.8% of the population.<sup>41</sup> The Board of Supervision expressed concern in the quality of the service provided, the second report in 1848 stating:

Some progress has been made towards a more coherent system of medical relief to the Poor, in most of the parishes in which it was defective; but in many the arrangements for this purpose are still far from being sufficient, and in some of the more remote Parishes, in which there are no resident medical practitioners, the means of affording medical relief to the Poor do not exist.<sup>42</sup>

The lack of a cohesive policy and inadequate financial resources inhibited sustained improvement, particularly in the remote northern and western regions. In that year the proportion of parishes providing medical relief in the Highland regions was exceptionally low; some parishes in Shetland and Skye provided no medical relief at all, and in the north-west and Highland Inverness 35% of parishes provided medical relief only through subscription to a hospital dispensary. In the remaining crofting counties no more than 19% of parishes in each county, (significantly less in West Argyll where the figure was 7%), provided medical relief by doctor or dispensary.<sup>43</sup> The difficulties were not only in the Highlands. Throughout the 880 Scottish parishes 360 of them had either no charge for medical relief or annual expenditure of less than £5.<sup>44</sup>

As a result of the inadequacies of medical attendance for the outdoor poor, and to reduce the burden of increased costs on the ratepayers, the Government voted in 1848 to provide an annual grant of £10,000 for poor law medical relief, to be called the Medical Relief Grant (MRG). It also prevented any increased charge falling solely on the rates. The report that introduced the scheme for the distribution of the grant stated:

It appears...that the provision for medical relief in Scotland is generally inadequate, that, except in a few parishes, the arrangements

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<sup>40</sup> *Report on Poor Law Medical Relief*, 1904, p.17.

<sup>41</sup> *Second Annual report of the Board of Supervision for Relief of the Poor (Scotland)*, 1948, p.iii.

<sup>42</sup> *Second Annual report of the Board of Supervision*, 1948, p.ix.

<sup>43</sup> Levitt and Smout, *State of the Scottish Working Class*, p.226.

<sup>44</sup> *Evidence of the Poor Law Medical Relief Enquiry*, Vol. II, 1904, Cd. 2022, Appendix LXI, p.275.



for its supply are made without any regular plan, and that the actual expenditure for this purpose is not in proportion to the comparative wants of the poor in each parish, or even in the country.<sup>45</sup>

The potential significance of the grant to the development of medical services was the imposition of the principle of a ‘minimum expenditure’, which stipulated that participation in the grant required a certain minimum level of expenditure on Poor Law Medical Relief from each parish in the year preceding the annual distribution. Essentially, this measure prevented parochial boards merely substituting the grant for existing spending, with no subsequent improvement in the adequacy of relief.

To determine the minimum expenditure, Scottish parishes were divided into seven classes according to density of population, and an average rate of expenditure per head was fixed for each class (Table 2.2). The calculations allocated parishes with denser populations a smaller rate per head. On production of vouchers confirming that the minimum expenditure had been met, each participating parish received a sum equal to one-half of its minimum expenditure.<sup>46</sup>

**Table 2.2 Scheme for distribution of the Medical Relief Grant, 1848**

Class	Approximate Population per square mile according to 1841 census	Minimum Expenditure per head on Medical Relief which will qualify for share of Grant	Total Amount of Minimum Expenditure for each class
I.	1 to 25	2d. per head	£2,182
II.	26 to 50	$1^{15}/_{16}$ d.	1,920
III.	51 to 100	$1^{14}/_{16}$ d.	2,694
IV.	101 to 200	$1^{13}/_{16}$ d.	2,749
V.	201 to 400	$1^{12}/_{16}$ d.	2,403
VI.	401 to 1000	$1^{11}/_{16}$ d.	1,704
VII.	1001 and upwards	$1^{10}/_{16}$ d.	5,686
Total,			£19,338
One half of which,			£9,669

**Source: Report on Poor Law Medical Relief , 1904, Cd. 2008, Part III, 5/17, p.6.**

A further condition of participation, of greatest potential significance to the Highland regions, was that all parishes should appoint qualified doctors, with fixed salaries to attend the poor. ‘It was proposed that all parishes, as a condition of participation in the grant, shall name legally qualified medical officers, at fixed salaries, to attend the

<sup>45</sup> *Report on Poor Law Medical Relief*, 1904, p 5-6; *R C Poor Laws*, 1910, Appendix CXCI (A), p.1045.

<sup>46</sup> The system and methodology used is set out in the Minutes of the Board of Supervision of 2nd Feb 1848, reproduced in the *Evidence and Appendices of the Committee on Poor Law Medical Relief (Scotland)*, Vol. II, 1904, Cd. 2022, pp.275-276.

poor.<sup>47</sup> Those officers were bound to obey the rules and regulations of the Board of Supervision and were liable to dismissal by the Board if they were considered to be incompetent. Doctors were also required to provide medicines and medical equipment.<sup>48</sup>

Additional rules by the Board increased its control over the management of participating parishes, with a corresponding decrease in parochial boards' autonomy, and thus control over their own affairs. (This represented a relative decline in autonomy as parish councils still retained a great deal of control over their affairs as in general the Board of Supervision could not enforce their decisions.) However, some parish councils initially decided not to participate; in the first year of its operation, 494 out of 881 Scottish parishes claimed a share of the grant.<sup>49</sup> In other areas the level of public expenditure was too low to entitle them to the grant. The parish of Orphir in Orkney, for example, appointed a doctor with a salary of £10, which was below the minimum expenditure required to entitle them to a share of the grant.<sup>50</sup>

Within Scotland there were variations in the levels of medical services provided. For example, from May 1846-7 the sum spent on medical relief in Orkney was just over £12 and in Shetland £61. This pattern was not confined to the Highlands though and occurred in other rural areas; for example, expenditure in Selkirk was £72 and £17 in Kinross. However, lowland counties did not suffer the extreme isolation of the North West and the Islands and were relatively close to urban centres so any comparison must be tempered by awareness of local conditions. Table 2.3 illustrates the benefits to Highland parishes had they been successful in increasing expenditure on medical relief.

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<sup>47</sup> Qualified was defined as being registered under the Medical Act, 1858, *Evidence and Appendices of the Committee on Poor Law Medical Relief (Scotland)*, Cd. 2022, Vol. II, App. LXVI, 1904, pp.283.

<sup>48</sup> *Evidence and Appendices, Committee on Poor Law Medical Relief (Scotland)*, App LXI, p.276. These clauses were the cause of much subsequent debate as many doctors claimed to be unfairly dismissed with no recourse to appeal and objected also to their salaries having to bear the cost of medicines.

<sup>49</sup> *RC Poor Laws*, 1910, App. CXC (A) p.1045.

<sup>50</sup> *Report on Poor Law Medical Relief*, 1904, Cd. 2008, p.17.

**Table 2.3 Actual expenditure upon medical relief in 1847, minimum expenditure to entitle participation in Medical Relief Grant and share of grant apportioned to each large Highland parish**

Parishes	Amount exp. in 1847			Min.Exp. required			Potential Share of grant		
	£	s	d	£	s	d	£	s	d
Latheron	29	16	8	61	13	0 <sup>11</sup> / <sub>16</sub>	30	10	0
Reay	11	1	11	23	8	6	11	10	0
Watten	6	7	9	10	11	0	5	0	0
Glenelg	20	0	0	22	14	10	11	0	0
Kilmallie	27	10	0	44	19	6	22	0	0
Kingussie	15	15	0	17	1	2	8	10	0
Portree	2	2	3	29	15	8	14	10	0
Sleat	2	10	6	22	11	0	11	0	0
North Uist	15	0	0	36	18	0	18	0	0
Urquhart	2	1	3	25	17	4	12	10	0
Fodderty	10	0	0	20	6	2	10	0	0
Gairloch	21	5	0	40	13	4	20	0	0
Lochbroom	20	4	0	39	19	10	19	10	0
Lochs	10	0	0	30	8	10	15	0	0
Roskeen	15	8	6	26	17	0	13	0	0

**Source: Departmental Committee on Poor Law Medical Relief (Scotland), 1904, Cd2022, Appendix LXI, Table III, p.277.**

Within Sutherland significant differences can be seen in expenditure on medical services. The total county expenditure was £181, but few parishes spent the minimum amount to entitle them to a share of the grant. (See Table 2.4).

The amounts paid were unlikely in some cases to make a significant difference to the level of service provided. For example, in the parish of Kildonan medical relief expenditure was high in proportion to the number of paupers in order to secure a doctor for the parish. Despite spending over £11 it only received £1 as a share of the grant. (The minimum expenditure required to entitle Kildonan to a share of the grant was £2 2s 8d, reflecting its low population density.)

**Table 2.4 Actual Expenditure on Medical Relief in 1847, Minimum Expenditure to entitle participation in Medical Relief Grant and Share of Grant Apportioned to each of the Parishes of Sutherland**

Sutherland Parishes	Amount Exp. in 1847			Min. Exp. required			(Potential) Share of grant		
	£	s	d	£	s	d	£	s	d
Assynt	15	16	6	26	9	8	13	0	0
*Clyne	15	17	11	14	14	2	7	0	0
*Creich	23	0	8	21	10	4	10	10	0
Dornoch	17	2	8	22	12	4	11	0	0
*Duirness,	10	3	6	9	4	10	4	10	0
Eddrachillis	13	17	0	14	3	2	7	0	0
Farr	10	12	6	18	9	6	9	0	0
Golspie	11	14	0	10	2	4	5	0	0
*Kildonan	11	10	4	2	2	8	1	0	0
Lairg	12	8	10	17	12	2	3	10	0
Loth	18	7	11	19	14	8	9	10	0
Rogart	10	11	0	12	10	2	8	10	0

\* parishes eligible for a share of the MRG

**Source: Departmental Committee on Poor Law Medical Relief (Scotland), 1904, Cd2022, Appendix LXI, Table IV, p.277.**

By 1851, the first year that the Board of Supervision considered that the grant was ‘in full working order under normal conditions’ once recording anomalies had been corrected, expenditure on poor law medical relief in Scotland had increased from £4,056 in 1846, an average of 9.75d per pauper, to £20,311, an average of 3s 5.25d per pauper. The situation in the Highlands however was not greatly improved in this period as evidenced by an enquiry initiated by the Royal College of Physicians in Edinburgh into the ‘Existing Deficiency of Medical Practitioners in the Highlands and Islands...’<sup>51</sup>

## **2.5 The Physicians’ Enquiry and Report 1850-1852**

Between 1850 and 1852 the ‘Physicians Enquiry’ sought to determine the extent of medical provision in the Highlands and Islands. The investigation collected evidence from Established and Free Church ministers throughout the Highlands. 320 questionnaires were sent to Ministers in 170 parishes of Argyll, Bute, Inverness, Ross, Sutherland, Caithness and Orkney and Shetland, requested details of the numbers of

<sup>51</sup> RCPE, CK4, 11, Statement regarding the Existing Deficiency of Medical Practitioners in the Highlands and Islands: being the Substance of a Report presented to the Royal College of Physicians of Edinburgh by a Committee appointed to make inquiries on the subject, Royal College of Physicians of Edinburgh, 1852. (RCPE Physicians Report: Statement.)

medical men and the areas covered by their practices, the impact of the absence of medical assistance and alternative sources of medical care. A high rate of returns were received, 200 responses from 155 parishes. Within those parishes 62 were 'adequately supplied' with medical officers, 52 'partially supplied' and 41 'rarely, if ever, visited by any regular practitioner'. The latter 'destitute parishes' as they were described in the report, containing a total population of 34,361, were situated mainly in Ross, Sutherland and the islands. The 93 adequately or partially supplied parishes contained 71 doctors and reported 'much suffering from accidental injuries that might be remedied were proper help at hand'.<sup>52</sup> The Committee, which included William P. Alison, was concerned not to alienate any of the doctors with any implied criticism of their practice in the Highland parishes and a second questionnaire was sent to the 71 medical practitioners identified by the ministers. Information was requested on the amount of work carried out, the level of payments received, whether they had 'any hope of amelioration of their conditions by any general measure or enactment'. The ensuing report indicated that the new Poor Law had not significantly altered conditions in the Highlands. The resulting data confirmed the continuing paucity of medical provision in the remoter areas and the onerous conditions under which the doctors had to work. Arduous journeys of many hours, sometimes lasting days, were undertaken by doctors trying to reach patients. All conceivable means of transport were utilised; boat, bicycle, horseback and foot, over moor, mountain and sea, and with no guarantee that a fee would be paid, salaries were modest, irregular and insecure. One doctor reported that from a population of 5,000 he could expect no more than £5 annually from private practice.<sup>53</sup>

A surgeon in the Hebrides summarised evocatively the impact of the lack of remuneration on his life and in the final sentence invokes the strong sense of professional and geographic isolation experienced in those areas:

The hardships incident to my situation are various and numerous. Owing to the miserable and inadequate remuneration I cannot afford, after supporting a wife and ten of a family, even to insure my life, or make any provision for myself or them. As my family increased, I was obliged to give up a medical periodical. I can scarcely afford to give my family the

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<sup>52</sup> *RCPE Physicians Report: Statement*, p.2. The 71 doctors were located in those 93 parishes which were partially or rarely visited by a doctor. No total is given of the number of additional doctors in the 62 parishes reported as being adequately supplied with medical practitioners.

<sup>53</sup> Royal College of Physicians Report: State of Medical Practice in the Highlands, (Report of the RCPE Enquiry) 1852, p.30. The sum of £5 in 1850 was approximately £292 in 2005. The National Archives, Currency Converter online. [www.nationalarchives.gov.uk/currency](http://www.nationalarchives.gov.uk/currency) (accessed October 2011.)

common rudiments of education. I have several inhabited islands to visit, which, in the winter and spring, is often attended with great risk and danger. I wish you would send a qualified person amongst us, to ascertain by personal observation our localities, and the superhuman labour attendant on our professional avocations.

This testimony will almost certainly have paralleled the existence of many other doctors in the remote Highlands. For example, Dr Wood from Sanday in Orkney stated ‘when called to neighbouring islands [he was] exposed to such storms, as to endanger my life and after visiting the patients, frequently return home without receiving any remuneration.’<sup>54</sup> The Small Isles reported that they had no doctor for seven years and were ten miles from the mainland and any medical assistance.<sup>55</sup> In addition to the lack of remuneration the most general grievances reported included the long, dangerous journeys to visit patients and the lack of suitable accommodation. The report also detailed the nature and scale of unqualified practitioners and untrained midwives who provided medical aid in the Highlands. Some remote areas relied solely on midwives and some parishes did not even have a midwife. In some districts doctors were forced to compete with unqualified practitioners, giving their services free to help establish themselves in the community. Instances of neighbours suggesting treatment for the sick were also documented. Ministers were also, sometimes reluctantly, a source of medical aid to their parishioners in the absence of a doctor, as were local heritors, a practice that continued for some time.<sup>56</sup> Parochial Boards appeared content to devolve responsibility ‘to private charity’.<sup>57</sup> Local landowners provided relief in a number of ways, by subsidising doctors salaries, providing nurses and issuing medicines. The proprietors of Kinlochranoch, for example, contributed to a private fund which funded the employment of a doctor.<sup>58</sup> The parallels with the findings of the Dewar enquiry in 1912 are striking and demonstrate the slow pace of progress during the nineteenth century in the primary function of supplying outlying communities with qualified medical attendance and in providing doctors with reasonable working conditions and salary. With prescient foresight one minister’s response to the enquiry called for ‘a grant of money sufficient

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<sup>54</sup> Report of the RCPE Enquiry, p.559.

<sup>55</sup> Report of the RCPE Enquiry, p.18.

<sup>56</sup> In his book reflecting on his life as Medical Officer for Yell and Fetlar from 1890 to 1935 Dr H.P. Taylor mentions a minister assisting at an impromptu home operation, having already ‘put on a tourniquet on the upper arm’ by the time the doctor had arrived. H.P. Taylor, *A Shetland Parish Doctor*, Lerwick, 1948, p.76.

<sup>57</sup> *RC Poor Laws and Relief of Distress*, 1844.

<sup>58</sup> *Dewar Evidence*, Q.17,404-05, p.362.

to give Salaries to Medical Practitioners locating themselves in the districts now destitute'.<sup>59</sup>

Attempts were made to tighten the legislation surrounding the employment of parochial doctors and their conditions of service. In 1871 the Select Committee enquiring into the operation of the Poor Law in Scotland made a number of recommendations, which had the potential to improve the parochial medical service. The Committee recommended that every parochial board should be required to appoint a medical officer 'at a suitable salary', whose position could not be terminated without the approval of the Board. The provision by each board of suitable housing and a dispensary at or near the doctor's house was also recommended. More radically, it was suggested that half the cost of the doctor's salary and medicines should be reimbursed by the Treasury.<sup>60</sup> Despite the introduction of a number of bills to Parliament in the 1870s, none were successful and the conditions of employment remained largely the same till the early decades of the twentieth century. Although the measures failed to be enacted, the issues raised demonstrate and also reinforced awareness of the problems still existing in Highland parishes twenty years after the Physicians' enquiry.

Of the 886 parishes in Scotland c.160 or approximately 19% were in the Highlands (including Highland Perthshire)<sup>61</sup> By 1880 only six Highland parishes did not employ a doctor: Sandwick, Walls and Yell in Shetland, the islands of Colonsay and Gigha in Argyll and the Small Isles in Inverness-shire. Another seven parishes did not comply with the terms of the MRG or were paid by fees only.<sup>62</sup>

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<sup>59</sup> RCPE Physicians Report: Statement, p.2.

<sup>60</sup> *PRML Report*, Vol. 1, p.15.

<sup>61</sup> The number of parishes in Highland Perthshire was 9 or 10, according to whether Kenmore and Killin were counted as one of two parishes.

<sup>62</sup> *Parish Medical Officers (Scotland)*, HMSO, London, 1905. The return to the Physicians Enquiry had stated, 'The people of Gigha feel the want of medical aid much; and complain of such want as a great deprivation.' Little had changed since 1850.

**Table 2.5 Numbers of parishes with/without Medical Officers in Highland parishes, 1880**

County	Parishes with MO & which complies with terms of MRG	Parishes with MO & which do not comply with terms of MRG	Doctors paid by fees only	Parishes with no MOs	Total
Argyll	33	1	2	2	38
Caithness	10	0	0	0	10
Inverness	31	0	1	1	31
Orkney & Shetland	21	3	6	3	33
Sutherland	13	0	0	0	13
Ross & Cromarty	33	0	0	0	33
Highland	8	2	0	0	9
Perthshire					
Total	159	4	3	6	167

**Source: Parish Medical Officers (Scotland), HMSO, London, 1905, p.7.**

The numbers of doctors therefore had increased from mid-century and in contrast to the Physicians Enquiry all Highland counties employed a doctor under the Poor Law in the majority of their parishes. Although the poor law medical service did facilitate the provision of medical care to the general public, poor conditions of practice, including income, tenure and accommodation, still persisted. As doctors often did not receive fees they were essentially subsidising the medical service. The establishment of the MRG was a key factor in bringing more doctors to Highland parishes, but as the proportion of the Grant available to parish councils diminished, local resources were sorely strained by increasing rates. The implications of changes to the MRG after 1880 will be addressed in the next chapter, together with the changing political and medical climate of the last decades of the twentieth century.



## CHAPTER THREE

### THE MODERNISATION OF MEDICAL PROVISION IN THE HIGHLANDS AND ISLANDS: TOWARDS THE DEWAR COMMISSION, c.1880-1912

The previous chapter examined the Medical Relief Grant (MRG), which encouraged parishes to employ doctors under the Poor Law. However, the system increasingly came under pressure as the proportion of the grant available to councils diminished, leading to an increase in the grant in 1882. This chapter will focus on the implications of the extension of the Grant and will address the changing ideologies and political environment which dominated the later decades of the nineteenth century and resulted in the Liberal reforms. The rise of the public health service and county government increased awareness of the need for effective medical services, in conjunction with civic housing and sanitary improvements.

#### 3.1 The extension of the Medical Relief Grant

In 1882 159 of 167 parishes employed a medical officer and complied with the terms of the MRG.<sup>1</sup> (See Table 2.5) In Scotland as a whole annual expenditure on medical relief increased over time and by 1881 expenditure on medical relief had increased to £40,438. By 1902 the figure had risen to £56,742. By 1880, 747 of 874, or 85% Scottish parishes participated in the MRG. Of that number 159 parishes or 18.2% of the Scottish total were located in the Highlands and Islands and 95.2% of Highland counties parishes were participating in the MRG in 1880.<sup>2</sup>

Inevitably, as the total sum available was fixed at £10,000, the proportion of grant paid to participating councils fell significantly as the amount of expenditure on medical relief increased. The system was becoming out-dated and unbalanced as both population and expenditure changed and in 1882 Parliament voted to increase the grant to £20,000.<sup>3</sup> The conditions on minimum expenditure were maintained but as it was considered that to re-assess and update the previous system would be time-consuming and not necessarily equitable it was decided to allocate the grant ‘on the principle of payments to each parish in proportion to its vouched expenditure on Medical Relief’. That more equitable system of allocation also had the advantage of

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<sup>11</sup> *Return of Parish Medical Officers (S)*, HMSO, 1905, p.7.

<sup>2</sup> See Chapter 2, Table 2.5, Numbers of parishes with/without Medical Officers in Highland parishes, 1880.

<sup>3</sup> From 1890-91 Section 22(4) of the *Local Government (Scotland) Act, 1889* made the grant a charge on the Local Taxation (Scotland) Account.

providing parishes with an incentive to increase doctors' salaries.<sup>4</sup> Table 3.1 demonstrates the increase in expenditure on medical services and the increasing number of parishes which were making a claim on the grant:

**Table 3.1 Expenditure on Medical Relief in Scotland 1846-1902**

Year	Total Exp.  (£)	Exp per head of pop. (s. d.)	Exp per pauper (s. d.)	no of parishes particip. in MRG	no par. not par ticip. in MRG
1846	4,056	0 0 <sup>1</sup> / <sub>4</sub>	0 9 <sup>3</sup> / <sub>4</sub>	-	-
1850	26,574	0 2 <sup>1</sup> / <sub>5</sub>	4 5 <sup>1</sup> / <sub>2</sub>	498	382
1855	27,166	0 2 <sup>1</sup> / <sub>4</sub>	4 7 <sup>1</sup> / <sub>4</sub>	594	298
1860	26,739	0 2 <sup>1</sup> / <sub>4</sub>	4 5	649	234
1865	31,400	0 2 <sup>1</sup> / <sub>5</sub>	4 10 <sup>3</sup> / <sub>4</sub>	694	191
1870	35,516	0 2 <sup>3</sup> / <sub>4</sub>	5 4 <sup>1</sup> / <sub>4</sub>	711	176
1875	34,771	0 2 <sup>1</sup> / <sub>5</sub>	6 7	736	150
1880	40,757	0 3	7 10 <sup>3</sup> / <sub>4</sub>	747	139
1885	39,878	0 2 <sup>1</sup> / <sub>5</sub>	8 4 <sup>1</sup> / <sub>4</sub>	774	112
1890	42,311	0 2 <sup>3</sup> / <sub>4</sub>	9 1 <sup>1</sup> / <sub>2</sub>	796	90
1895	48,091	0 2 <sup>3</sup> / <sub>4</sub>	10 0 <sup>1</sup> / <sub>2</sub>	798	79
1900	53,468	0 3 <sup>1</sup> / <sub>4</sub>	10 9 <sup>1</sup> / <sub>2</sub>	797	80
1902	56,742	0 3	11 3	795	79

**Source: Report of the Departmental Committee on the Poor Law Medical Service (Scotland), Minutes of Evidence and Appendices, 1904, Cmd. 2002, App. LVI, p.271.**

From 1882 therefore, the doctor's salary was to represent the level of expenditure required to participate in the grant. Salary levels and security of tenure were controversial; they determined the standard of living and often the social status of a doctor and thus influenced the quality of doctor who would be attracted to work in the often difficult circumstances found in the Highlands. The supply of medicines and medical appliances, formerly to be met from the doctor's salary – which had always been a contentious issue – was ended by the new rules of the MRG.<sup>5</sup> The Board were not prescriptive in the monitoring of this ruling and took a pragmatic approach to the inevitability of its gradual demise. 'It is not proposed to make the observance on the rule that salary shall be separated from drugs a condition of receiving the contribution; but the Board have no doubt that the recommendation which has already

<sup>4</sup> *PRML Evidence*, App. LXII, p.278; *PRML Evidence*, App. LXIII, Enclosure to No.5, p.279.

<sup>5</sup> *PRML Evidence*, App. LXIII, No.11, p.281.

been adopted by a great majority of the Parochial Boards will be forthwith given effect to by the remainder.’<sup>6</sup>

In practice the requirement of doctors to supply medicines from their salaries was only gradually phased out. In 1902 over 18% of doctors’ salaries throughout the Highlands still included the cost of medicines and a further 26% were given a fixed sum in addition to their salary to cover the cost of medicines.

**Table 3.2 Highland parishes requiring the parochial medical officer to provide medicines from their salary and those with a fixed sum in addition to their salary**

County	No of parishes	No of parishes where the cost of medicines were included in salary and % of total parishes	Cost of medicines in addition to salary and % of total parishes
Argyll	39	6 (15.4%)	11 (28.2%)
Inverness	33	8 (24.2%)	7 (21.2%)
R & Cromarty	33	1 (3%)	7 (21.2%)
H Perthshire <sup>7</sup>	10	3 (30%)	3 (30%)
Sutherland	13	3 (30%)	2 (23%)
Caithness	10	0 (0%)	5 (50%)
Orkney	21	2 (9.5%)	7 (33.3%)
Shetland	12	9 (75%)	3 (25%)
Total	171	32 (18.7%)	45 (26%)

**Source: Parish Medical Officers (Scotland), HMSO, 1905.**

Although this was not confined to the Highland parishes it was more prevalent in rural areas. There was a significant variation within areas, often reflecting local conditions and established practice. In the Argyll parish of Glenorchy and Inishail the doctor, from his salary of £100 1s, was required to provide ‘all medicines for paupers of the parish resident therein’. Of the 12 parish doctors in Shetland nine were expected to provide medicines and the other three received a fixed sum in addition to their salaries. Where there was more than one medical officer one would have responsibility for providing medicines, the cost of which was either included in their salary or provided in addition to it. In Inverary one doctor was provided with £1 yearly for medicines, while prescriptions issued by the other doctor were supplied by the chemist. A smaller proportion of doctors had a contract with a chemist, some of

<sup>6</sup> *PRML, Evidence*, App. LXIII, No 8, p.281.

<sup>7</sup> Highland Perthshire comprised the parishes of Blair-Atholl, Dull, Dunkeld and Dowally, Fortingall, Kenmore, Little Dunkeld, Logierait, Moulin and Weem, as constituted in the *Local Government (Scotland) Act, 1889*.

whom charged the parish council less than other customers, but this was more prevalent in the burghs.

Pragmatically, the practice was retained longer in more remote parishes, where there were no chemists and dispensaries. In Harris, for example, medicines were supplied by the medical officer of the parish as there was no chemist. Of the 39 parishes in Argyll only six included medicines in the medical officer's salary.<sup>8</sup> Variations in practice were determined by parish councils and local circumstances and salaries frequently included, in addition to the poor law salary, lunacy and vaccination salaries. In addition doctors could be paid fees for each lunacy certificate issued and visit made, which were often paid at an enhanced rate for the poor of another parish, the fee dependent on the distance travelled. The doctor of Kiltarlity in Inverness-shire was paid £1 1s for each lunacy certificate issued, 5s for every visit he made in his own parish and 7s 6d or more for quarterly visits to 'other parish lunatics' outwith his parish of employment, which varied according to the distance.

Therefore, following the increase of the MRG in 1882, the rules provided doctors with a further degree of security of income in the stipulation that the approval of the Board of Supervision was required before any alteration of the medical officers' salaries was effected, which also applied to proposed increases in salary.<sup>9</sup>

Nonetheless, the increases in the grant were of short-lived benefit to the Highlands as several years later the rule defining 'medical relief' for the purpose of participation in the grant was altered. In 1885 half the cost of trained sick nursing in poorhouses was allowed as a first charge against the grant, the balance distributed on the basis of parish expenditure on medical relief. This ruling significantly reduced the benefits of the grant to the Highlands, which had few poorhouses and where relief was primarily outdoor. In 1911 only eight poorhouses in the Highlands employed trained sick nurses, and being smaller than city poorhouses, they employed fewer trained nurses. Of £7,188 set against the grant for Scotland as a whole for trained sick nursing, only £271 14s 9d was allocated to poorhouses in the Highlands (See Table 3.3).<sup>10</sup>

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<sup>8</sup> *Return of Parish Medical Officers*, 1905, pp.6, 56.

<sup>9</sup> *PRML, Evidence*, App. LXVI, Rules framed by the Board of Supervision ... as to Medical Relief of the Poor, 11, p.281.

<sup>10</sup> *Dewar Report*, p.20.

**Table 3.3 Expenditure on trained sick nursing in Scotland, 1885-1911**

Year	Amount(£)
1885	264
1890	977
1895	2000
1900	2800
1905	4500
1911	7188

**Source: Report of the Dewar Committee, 1912, Cd 6556, p20.**

The amendment to the working of the MRG immediately diminished the proportion available for outdoor medical services and effectively discriminated against the Highlands. In 1912 the total amount paid to Highland parochial councils under the grant was less than £3,000.<sup>11</sup>

**Table 3.4 Sum expended on medical relief (MR), per head of population and cost per pauper in a selection of Lowland counties and in the Highland counties in 1847 and 1902**

	1847		1902		Cost of MR <sup>12</sup> per pauper	
	Sum expended on MR	Rate per head	Sum exp. on MR	Rate per head	s.	d.
	£	d.	£	d.		
Argyll	364	0.09	2,697	8.79	24	5
Caithness	147	0.94	782	5.54	12	1
Inverness	274	0.66	2,895	7.66	18	1
Orkney	12	0.09	771	6.45	18	5
Shetland	61	0.48	604	5.15	13	4
R & Cromarty	453	1.36	2,904	9.12	18	4
Sutherland	181	1.83	1,331	14.9	28	12
Highland counties	1,492	0.78	11,984	8.23		19.00
Aberdeen	621	0.77	2,957	2.26	8	10
Nairn	7	1.92	111	3.05	8	6
Fife	140	1.11	1,637	1.80	9	5
Lanark	428	1.64	15,142	2.76	9	11
Renfrew	154	1.05	2,460	2.01	8	11
Kinross	17	0.54	81	2.78	18	7
Berwick	34	1.80	519	4.04	17	9
Dumfries	308	1.01	1,266	4.19	17	1
Roxburgh	338	1.75	607	2.97	13	5
Selkirk	72	2.33	604	2.97	13	5
Wigton	243	1.48	858	6.30	16	6
Scotland	12,879	11.14	56,742	3.05	11	3

**Source: Table produced from the Departmental Committee On Poor Law, Medical Relief (Scotland), 1904, Appendices, LIX, LXI, Cd.2022, pp.274, 276.**

<sup>11</sup> *Dewar Report*, Cd. 6559, Vol. I, 1912, p.32.

<sup>12</sup> Figures have been rounded to nearest penny.

But the grant did focus attention on the issue of medical relief and acted as an incentive to parishes to increase their expenditure sufficiently to enable them to participate in the grant. The General Superintendent of the Poor in the Northern Highland District believed that the improvements in the medical relief service which were evident to him in 1902 were ‘chiefly through the operation of the MRG’.<sup>13</sup> Indeed by 1911 only five parishes in the Highlands, with a total population of 1,676, supporting only 25 paupers receiving outdoor relief, were not participating in the grant.<sup>14</sup> Furthermore, those parishes not claiming the MRG were not necessarily without a medical officer. The 1901 Census reported only one Highland parish, Gigha, in the county of Argyll, with six registered paupers, as having no medical officer.<sup>15</sup> Three further parishes in Argyll, Craginish, Inverchaolain and Kilmodan, with a total of fifteen paupers, paid their medical officer by fees.<sup>16</sup> The parish of Orphir in Orkney, with 22 paupers and eight dependents, paid a salary of £10 to the medical officer, which was less than the minimum required and therefore did not entitle them to participate in the MRG.<sup>17</sup>

Nevertheless, it must be borne in mind that improvements in the numbers of doctors in the Highland parishes did not necessarily represent improvements overall, as there was a high level of local variation in salaries and working conditions. To achieve substantial improvements in medical provision in the Highlands a general increase in qualified doctors was essential and the amendments to the grant effectively limited any significant increase in medical practitioners from that source. As with the original £10,000 grant, as the cost of medical relief increased, the fixed sum available to meet expenditure declined. In 1883 the grant was distributed at the rate of 10s 9d per £ of medical relief expenditure but by 1911 the rate had fallen to 4s 3d.<sup>18</sup> The parish of Evie and Rendall in Orkney was given £31 16s 1d for Poor Law medical relief in 1901; ten years later the amount had fallen to £19 11s despite expenditure being £7 higher. This was not uncommon as Table 3.5 illustrates in the four parishes of the Lews.

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<sup>13</sup> *Report on Poor Law Medical Relief*, 1904, p.16.

<sup>14</sup> *Dewar Report*, p.17.

<sup>15</sup> *Report on PLMS*, 1904, LV(11), p.270.

<sup>16</sup> *Report on PLMS*, 1904, LV(1), p.270.

<sup>17</sup> *Report on PLMS*, 1904, LV(111), p.xx.

<sup>18</sup> *Dewar Report*, p.18.

**Table 3.5 Expenditure on Medical Relief in The Lews in 1896 and 1905**

Year	Barvas £			Lochs £			Stornoway £			Uig £		
	1	2	3	1	2	3	1	2	3	1	2	3
1896	175 / 1083 / 72			135 / 1260 / 64			243 / 2740 / 99			181 / 1027 / 74		
1905	210 / 1543 / 58			188 / 1768 / 60			281 / 4076 / 84			200 / 1543 / 66		

1 Medical Relief Expenditure.

2 Total Poor Relief Expenditure.

3 Medical Relief Grant.

**Source: Reports on the Burden of the existing Rates and the General Financial Position of the Outer Hebrides, Cd3014, 1906, pp. xxxix, lxi, lv.**

The proportional decrease in the grant was particularly serious for the Highland parishes, where the cost of maintaining a medical officer was disproportionately high. For example, as has been seen in the parish of Uig, medical relief charges formed 12.9% of the whole cost of poor relief; for Scotland, the average figure was 4.75%. The increased cost was required to secure a resident medical practitioner.<sup>19</sup>

Nevertheless, despite this gradual improvement Table 3.5 reveals the excessively high cost of medical services to the Highland population. In 1847, the year before the MRG was established, Highland counties spent £1,492 on medical relief, just over 11% of the total amount spent in Scotland. By 1902 expenditure had risen by in the Highland counties to £11,984, 21.1% of total Scottish expenditure. While the average rate of medical relief per person in Scotland was 3.05d., the Highland counties paid an average of 8.23d. The disproportionately high level of expenditure is clearly illustrated in the cost of medical relief per pauper. The cost of providing medical relief to each pauper in Sutherland and Argyll counties was over 28s and 24s respectively and ranging from 12s to 18s per pauper in the other Highland counties. Those high levels of expenditure per pauper placed a heavy burden on the rates; in 1906 the parish of Barra had the highest poor rate in Scotland of 13s 3d, compared with  $\frac{1}{16}$  d. paid by Traquair, a rural but less remote and more affluent parish south of Edinburgh.<sup>20</sup>

Other Scottish counties also had high rates per pauper, such as Kinross, Wigton and Berwick, but although the rate per pauper was high, the rate per head of population

<sup>19</sup> *Report on Burden of Existing Rates and the General Financial Position of the Outer Hebrides*, Cd.3014, 1906.

<sup>20</sup> *Royal Commission on the Poor Laws*, Appendix No. CLIX. (C), p.895.

was considerably lower, reflecting higher densities of population. The rate of 9.12d. per head of population in Ross and Cromarty (with a population of 76,450) which had an expenditure of over 18s per pauper can be contrasted with Dumfries, (population 72,571) where although the rate per pauper was relatively high at 17s 1d, the rate per head of population was lower at 4.19d. Likewise, though Kinross county, with a low population of 6,981, had a high rate per pauper of 18s. 7d, the cost per head of population was considerably lower at 2.78d. Lowland counties in general, though many were at a distance from the industrial centres, did not suffer the same degree of remoteness, poverty or economic vulnerability as the Highland counties, particularly those in the north and west. The greater number of poorhouses reduced the cost of caring for paupers, and they benefited, for example, from the changes in the MRG which enabled them to claim the cost of trained sick nursing. The costs of employing a doctor were also lower, reflecting fewer outdoor paupers and greater access to private practice. In Argyll, where the cost of maintaining each pauper was over 24s, parish doctors salaries ranged considerably from £9 in Kilninver and Kilmore to £130 in Lismore and Appin. Glenelg was required to pay £260 to secure the services of a parish medical officer, and South Uist paid £130.<sup>21</sup>

### **3.2 Public health service: policy and ideology**

Throughout the later nineteenth and early twentieth centuries, a number of statutes, including the Public Health (Scotland) Acts of 1867 and 1897, which led to the employment of County Medical Officers of Health, were passed through Parliament. They further advanced the principle of state intervention in the public sphere, which had been developing from the mid-century cholera epidemics, eventually culminating in the creation of the National Health Service in 1947. The Public Health Movement was a reaction to the pressures of increasing population and urbanisation during the nineteenth century and the insanitary, overcrowded conditions which increased as the century progressed. It was facilitated both by a changing political climate and the strengthening ‘Alisonian’ beliefs of liberal doctors, poor law administrators and politicians, who disputed the premise of moral failure as a reason for poverty and destitution. They believed poverty was the main cause of disease and supported the

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<sup>21</sup> *Return showing for each parish in Scotland as at 1st day in December 1902, the salaries and Fees paid to outdoor Medical Officers under the Poor Law, Lunacy and Vaccination Acts, and the arrangements made by the Parish Council for supplying medicines and medical appliances to poor persons, Parish Medical Officers (Scotland)*, HMSO, London, 1905.



increasing role of central government in alleviating both poverty and disease. They believed that the ‘philosophy of moral discrimination’ had not succeeded in reducing the numbers of claimants for poor relief and increasingly took the view that altering the poor’s physical environment, freeing them from disease and hunger, would help them to free themselves from poverty more effectively than any amount of self-help, meagre financial assistance or blame.<sup>22</sup>

Levitt has identified three key developments which ‘created the impetus for change’ in Scotland; the appointment in 1901 of Leslie MacKenzie, Medical Inspector for the Local Government Board for Scotland, as the first Chief Medical Inspector; the appointment in 1905 of John Sinclair (Liberal MP for Forfarshire) as Scottish Secretary, who established a radical Scottish administration comprised of largely progressive, non-poor law members – both held well-established, progressive views on the causes of poverty and the ineffectiveness and inability of the Scottish parochial system to alleviate poverty – and the establishment of the Poor Law Commission in the same year.<sup>23</sup> These events facilitated informed debate and enabled wide-ranging public health and welfare legislation developments in Scottish welfare and the public health system. Evidence from numerous social enquiries at the end of the nineteenth century and beginning of the twentieth century strengthened liberal social ideology (See Chapter 4); key developments in the field of public health following during the later nineteenth century. Statutes aimed at increasing public cleanliness had been passed throughout the nineteenth century, increasing in regularity from mid-century following the cholera epidemics. Cholera’s lack of sensitivity to middle class refinement, and the fear it generated, was a major factor in municipal efforts to secure safe water supplies and the expansion of public health measures. At the end of the century the fear of cholera outbreaks remained; fear of polluted rivers was centred on the risk to health, rather than primarily from the threat to economic concerns, such as fishing. ‘It is true that in so large a body of water unpurified sewage will soon become oxidised to a considerable extent, but, unfortunately, the spores of such diseases as

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<sup>22</sup> Levitt, *Poverty and Welfare in Scotland 1890-1948*, 1988, Edinburgh, p 44.

<sup>23</sup> For a detailed analysis of these issues see Levitt, *Poverty and Welfare*, pp. 44-73; *Who was Who*, 1929-1940; *Medical Directory*, 1922; Sir, (William) Leslie Mackenzie, (1862-1935), health administrator, by Ian Levitt, *Oxford Dictionary of National Biography* (DNB), <http://www.oxforddnb.com/articles/55/55652-nav.html?back>, accessed 03/05/09.

Enteric Fever and Cholera are well-known to be specifically resistant of nature's beneficent processes.'<sup>24</sup>

The Public Health (Scotland) Act, 1867, first brought together that piecemeal legislation, a process extended by the Public Health (Scotland) Act, 1897. Under the 1867 Act the Board of Supervision became the central sanitary authority. Parochial Boards became the sanitary authorities at the local level, with powers to aid the prevention of infectious disease by the provision of hospitals and by improving sanitation. Under the Act the parochial boards could appoint a medical officer of health but if required by the Board of Supervision this became mandatory.

In the Highlands the 1867 Act, being largely permissive, had little impact. The Poor Law Inspector for the North Highland District reported in 1885 that 'the Act remained practically a dead letter', in partial operation in only a few areas, with parochial boards inadequately set up to improve sanitation. 'The conclusion to which I have come is, that the persons who are usually members of Parochial Boards in rural districts are really unfit to be sanitary authorities'. He recommended the appointment of full-time paid 'independent and skilled officers', sanitary officers. In 1871 the Board of Supervision required parishes with towns or villages with populations over 2000 to appoint sanitary inspectors, but many areas in the Highlands with scattered populations fell under this level. The ruling had little effect in practice as a common course of action was to add this role to the medical officer of health's remit and salary, at a level unlikely to affect any improvement in sanitation.<sup>25</sup> One doctor reported in 1890, 'The duties of the MOH were nominal, except the writing of an annual report on the health and sanitation...'.<sup>26</sup>

Nevertheless, both the 1867 and 1897 acts helped to raise awareness of the relationship between disease and insanitary conditions, and consolidated and amended the laws relating to public health in Scotland. They laid the foundations for more robust public health measures at the local and national level. Under the 1897 Act local authorities were required to appoint a medical officer of health and sanitary inspector subject to the administrative oversight of the Local Government Board for Scotland, which in 1894 superseded the Board of Supervision.

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<sup>24</sup> P&K Archives, Report by County Medical Officer and Sanitary Inspector on Pollution of the Tay, CC1/3/1/1, p.312.

<sup>25</sup> J. P. Day, *Public Administration in the Highlands*, p295.

<sup>26</sup> H.P. Taylor, *A Shetland Parish Doctor*, 1948, Lerwick, p. 20.

### 3.3 The establishment of county government

Prior to that, the Local Government (Scotland) Act, 1889, introduced measures which aimed at taking ‘ the whole of public health into consideration’. It established county government, creating county councils – the first public bodies responsible for providing administrative and financial oversight at county level – and District Committees. The County Councils were responsible for almost all matters of local government, including the provisions of the Public Health Acts. The 1889 Act effectively reduced the number of local sanitary authorities from 1046 to 305, making the District Committees the local sanitary authority.

The Act was a significant step towards the further development and co-ordination of public health measures. County Councils were responsible for management of everything except the poor law, education, lunacy and licensing, which were centrally managed and locally administered by other bodies. The most powerful arm of the County Council was the Finance Committee on which the most powerful figures sat and which controlled and approved all finance and raised rates to fund annual expenditure. Within the regulations placed on them by central government County Councils were powerful bodies, headed by the local aristocracy. The Perthshire County Council included the Duke of Atholl, Viscount Stormont and Colonel Stirling (all of whom sat on the Finance Committee).

Each county was divided into Districts, normally six, each with a committee comprised of local councillors and a representative each from the parish council, (which administered the poor law in each locality), and the burgh. District Committees did not have the power to apply rates to fund expenditure but could apply to the County Council for approval of expenditure. They were powerful bodies, nevertheless, with wide powers in the implementation of the Public Health Acts.<sup>27</sup> At a local level they had a key role in the implementation of the Public Health Acts, supported by the local medical and sanitary officers employed under the Act.<sup>28</sup> One of the first actions of the Highland District Council, which met for its first meeting at

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<sup>27</sup> P&K Archives, CC1/6/2/7A, Evidence of the standing of the committee can be seen in the membership of the committee. The Highland District Committee in 1898 was chaired by the Duke of Atholl, pp.102-3.

<sup>28</sup> William Edward Whyte, *Local Government in Scotland*, London, 1936, pp. 7-12.

Logierait Inn, Balinluig, on 12 July 1890, was to establish a committee ‘to take the whole of public health into consideration’.<sup>29</sup>

A major clause in the 1889 Act was the requirement for the first time that each Council should appoint and pay for both a county medical officer and sanitary inspector and, in addition, district medical and sanitary officers as required. Furthermore and significantly, the Act required that the medical officer should be qualified and could not be dismissed without the approval of the Board of Supervision, giving public health doctors security of tenure for the first time – which was not available to parish medical officers. The new Councils had some degree of flexibility in the salaries and conditions of service of the newly appointed medical and sanitary officers, but their decisions were subject to the approval of the Board of Supervision, which monitored carefully the actions of the County Councils and who were quick to reiterate the rules they had set down, if they believed they were not being applied correctly.

For example, in 1890 Perthshire County Council Finance Committee reflected on the regulations relating to the duties and salary of the County Medical Officer (CMO) and recommended ‘adoption with minor adjustment’. They had discussed a joint appointment with another council, a proposal which was rejected as it was feared it would have created ‘jealousy’ within the counties and thus be unworkable. It was also believed that there was insufficient work for the appointment of a medical officer and sanitary inspector for the county and for each of the districts.<sup>30</sup> Their preference therefore was to appoint a county medical officer for the City and five district medical officers. The County Medical Officer was to have responsibility for the general supervision of the whole county and would be permitted to carry out private practice. They proposed to pay a fixed salary of £200 per annum, plus travelling expenses and 15s for each night the County Medical Officer was required to be away from home. He was required to live in Perth or its close vicinity and was not permitted to act as medical officer in any district, burgh or parish, except Perth. He was permitted to engage in private practice and it was recommended that he took the sanitary degree or diploma.<sup>31</sup> Dr JT Graham, MDCM, MRCSE, a resident of Perth accepted the post, which required the approval of the Secretary of State for Scotland,

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<sup>29</sup> P&K Archives, CC1/6/2/3, Minutes of the Highland District Committee, 1891, pp.102-3.

<sup>30</sup> P&K Archives, CC1/3/1/1, Vol.1, March 1890, p.44.

<sup>31</sup> Recommended under section 54 of the 1889 Act.

on the recommendation of the Board of Supervision.<sup>32</sup> The Highland District Committee also appointed four medical officers in Aberfeldy, Rannoch, Pitlochry and Dunkeld at an annual salary of £20, with £5 extra paid during the first year.<sup>33</sup>

Following the appointments the Board of Supervision did not approve the appointments. It insisted that in order to benefit from the local Taxation Account, which paid for the costs of the County Medical Officer's and the district medical officers, they must 'they must devote their whole time to their duties, and be paid adequate salaries accordingly, beside travelling expenses'.<sup>34</sup> It also stated that the salary of £200 did not appear to be adequate and recommended that the County Medical Officer was also appointed as chief medical officer of the district and that the districts should pay a proportion of the cost of the County Medical Officer's salary.<sup>35</sup> A special meeting of the County Council was called to reconsider the matter and resolve the deadlock. Agreement was reached that each district would contribute £20, the additional £100 not to augment directly the County Medical Officer's salary, whose appointment and salary was to be amended, 'such as the Board of Supervision would approve' and be eligible for the grant from the £15,000 Taxation Account, funded under the auspices of the Local Taxation Act. His salary was increased to £600 and 'his whole time' devoted to the duties of the County and Districts; he was not permitted to engage in private practice.

The Finance Committee resolved to refuse all claims for compensation made by local medical officers and sanitary inspectors, compensation 'not warranted by tenure of their office' and also on the grounds that they were acting as officers of the district councils and removed by the Board of Supervision.<sup>36</sup> The decision met with resistance from the districts which were then liable for contributions towards both the County Medical Officer's salary in his role as Chief Medical Officer and for the Sanitary Inspector. Regardless of this dissent the Finance Committee agreed that £300 of the County Medical Officer's salary was to be allocated among the districts, with the remaining £300 to be met from the County funds. Travelling expenses of £110 per annum were agreed for both County Medical Officer and the Sanitary Inspector, the

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<sup>32</sup> Regulations issued on 22 August 1890.

<sup>33</sup> P&K Archives, CC1/6/2/3, Report on Medical Officers & Sanitary Inspectors, Minutes of the Highland District Committee, 1890, p.28.

<sup>34</sup> Letter from the Board of Supervision, 24 January 1891, quoted in CC/3/1/1, p.124.

<sup>35</sup> The example of Fife was given, where a salary of £500 was paid, the County contributing £300 and the Districts £50 each.

<sup>36</sup> P&K Archives, CC1/3/1/1, Minutes of the County Council, 1891, pp.121-188.

fixed sum disputed by Dr Graham, which he claimed demonstrated a lack of confidence, which he felt should exist between himself and the Council. It was agreed that both would maintain a record of expenditure, and that expenditure over the set amount would be reimbursed. At a subsequent meeting in December 1892 it was reported that the sum of £110 was insufficient, and was in fact exceeded in 10.5 months, reflecting the amount of travelling carried out in the course of their work within the county. Consequently, the sum allowed was raised to £125.<sup>37</sup> In the Highland District a local sanitary inspector was employed at a salary of £75; the old Parochial inspectors 'dispensed with'.<sup>38</sup> These events demonstrate the increasing emphasis on the improvement of sanitation and the eradication of 'nuisance' materials.

The medical officer appointments that had been made at district level were also cancelled and the contracts of some existing medical officers and one sanitary inspector, with salaries ranging from £2 - £10, terminated. In his first annual report the County Medical Officer recorded his misgivings at the decision to dismiss the local medical officers, firstly, the loss of their local knowledge and co-operation and secondly, as the local medical officers had been responsible for supplying the statistics on incidence of disease at the local level. From 1889, in an attempt to prevent the occurrence and spread of infectious disease, it was made a requirement by law that the County Medical Officer should be notified of any instance of infectious disease occurring outwith the confines of a hospital. However, the permissive nature of the legislation delayed implementation and it was September 1893 before the Highland Committee moved for it to be adopted.<sup>39</sup> In a letter to the District Committee in 1891 Dr Graham expanded on these issues; he expressed concern regarding the delays which would occur by his having to make special visits to advise the local Sanitary Inspector during incidences of fever and contagious disease, whereas, as the medical officers were based locally they could provide him with monthly reports on the incidence of disease or on the likelihood of disease being caused by 'influences capable of removal which come to their knowledge in the performance of their daily

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<sup>37</sup> P&K Archives, CC1/31/1, Minute of the Finance Committee, 11/4/92, pp.238-9, 301-2.

<sup>38</sup> P&K Archives, CC1/3/1/7, Minutes of the County Council, 1891, pp.232-235.

<sup>39</sup> The Infectious Disease (Notification) Act, 1889; P&K Archives, CC1/6/2/3, Minutes of the Highland District Council, 1893, p.182.

work.’<sup>40</sup> As he reported in his annual report, ‘Should these District Committees adhere to their decision of dismissing their officers, some arrangement will require to be made whereby Sickness Returns from all the medical men throughout the County may be obtained’.<sup>41</sup>

In May 1893 the government amended their views on the issue of private practice, possibly the result of informal lobbying from senior members of the Councils. A letter from Whitehall, from the Under Secretary of State, reported that though Secretary of State, Sir George Trevelyan, shared the opinion of Lord Lothian - former Scottish Secretary - that, as a rule, County Medical Officers should not engage in private practice, he accepted that exceptions might be necessary in certain situations and that County Medical Officer’s private practice would ‘no longer necessarily debar them from sharing in the contribution’ of the government’s Taxation grant.<sup>42</sup> That decision was a clear recognition and acceptance of the difficulties faced by remote areas. Rather than depending on the full-time services of the County Medical Officer, the focus had moved to ensuring efficiency:

Where the Board is satisfied that the service is being well administered the Grant will be made. Where the Board finds, on investigation that the administration is not satisfactory, whether this be due to the fact that the Medical Officer is engaged too exclusively in his private affairs, or to other causes, it will be their duty to report the fact to the Secretary for Scotland, who will not hesitate to withhold the Grant, if they recommend it.<sup>43</sup>

The Highland District eventually appointed four medical practitioners as district medical officers in Dunkeld, Pitlochry, Aberfeldy and Kinloch Rannoch, their annual salary in the region of £8 a year each.<sup>44</sup> That level of salary clearly indicates that it was not the sole income of the post holders.

These events illustrate the increasing power held by both the Board of Supervision and to a lesser extent, the County Council. It also reflects the vulnerable position of the local medical officers, who did not have security of tenure. The actions of the Council, though motivated by financial stringency, resulted in the County Medical

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<sup>40</sup> P&K Archives, CC1/6/2/3, Minute of the Quarterly meeting of the Highland District Committee, 5 September 1891, pp.102-3; over 20 years later Dr Graham reiterated these same concerns to the Dewar Enquiry, Q17,511, p.364.

<sup>41</sup> P&K Archives, CC1/3/1/7, First Annual report by the County Medical Officer, 1891, p.320.

<sup>42</sup> P&K Archives, CC1/3/1/1, Copy letter to County Council from Board of Supervision, 1893, p.346.

<sup>43</sup> P&K Archives, C/3/1/1, Copy letter to County Council from Board of Supervision, 1893, p.346-7.

<sup>44</sup> P&K Archives, CC1/6/2/3, Minutes and Accounts of the Highland District Council, 1891, p.266.

Officer working very closely with the Sanitary Inspectors and general practitioners throughout the County, which gave them a detailed knowledge of local conditions that they would not have acquired personally had they not had the dual responsibility of county and district medical officer. This was of course particularly important where there were few local medical officers.

While the raft of legislation enacted during the second half of the nineteenth century increased public health employment opportunities for doctors, it also increased the web of bureaucratic appointments.<sup>45</sup> The trend continued into the twentieth century. Crowther and Dupree have reported that almost 60% of doctors who contributed their details to the 1911 Medical Directory reported two or more appointments, including public appointments, the military, insurance companies, post offices, asylums, prisons, collieries and private companies.<sup>46</sup>

A parish council medical officer could be employed as an inspector of the poor, clerk, collector, parish medical officer, public vaccinator, registrar and footpath inspector. For example, following the passing of the Education Act in 1908 the County Medical Officer of Perth was appointed the Principal School Medical Officer.<sup>47</sup> The district committee hired a clerk, collector, road surveyor, chief district medical officer of health, district medical officer of health, chief district sanitary inspector and district sanitary inspector.<sup>48</sup> Under the school board was a clerk and a compulsory officer. Parish officials were themselves over-inspected receiving visits from a lunacy inspector, the general superintendent of the Local Government Board, registration and vaccination, education, county sanitary, board of agriculture and fisheries, factory and workshop, food and drugs, weights and measures and poor-house inspectors plus visits from the county medical officer and Congested Districts Board's Inspector of Roads.<sup>49</sup>

Although many of the above officials were not related directly to medical provision, it illustrates the complexity of the bureaucracy in Scottish parishes. Many of the posts

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<sup>45</sup> This was common throughout Scotland and was not prevalent only in the Highlands. Relevant legislation included the Vaccination Act of 1863, the Public Health Acts of 1867 and 1897, the 1889 Local Government Acts of 1889 and 1894.

<sup>46</sup> M.W. Dupree & A. Crowther, A profile of the Medical Profession in Scotland in the early twentieth century: the Medical Directory as a historical source, *Bulletin of the History of Medicine*, 1991, 65, pp.223-224.

<sup>47</sup> P&K Archives, CC1/3/1/13, Minutes of the County Council, 1908-1910, pp.591-595.

<sup>48</sup> Dupree and Crowther list the wide range of occupations held by doctors throughout Scotland, documented in the *Medical Directory* in 1911. M.W. Dupree and M.A. Crowther, *Profile of the medical profession*, pp.209-233.

<sup>49</sup> *RC Poor Laws, 1909*, Minute of Evidence. 1910, p.832.



such as Parish Medical officer, Medical Officer of Health, Vaccinator and School Board Officer were duplicated and held by the doctor. In addition to supplementing their salaries it could provide enhanced status within communities. However, for the majority it was necessary simply to survive. Dr Graham, Medical Officer of Health for Perth reported to the Dewar Commission that in his opinion doctors in Highland Perthshire received less than half the money they worked for, their income ‘made up from a comparatively large sum from the poor rate, and certain other appointments, and then they have got to scramble for their fees among a very poor population, who are usually unable to pay inadequate fees’. This, of course, paralleled the situation in other remote areas and he quickly tempered his statement by stating that the payment of large fees from the poor rate was applicable to only a few cases.<sup>50</sup>

The duplication of agencies could also lead to inefficiency. The Chief District Medical Officer of Health for Harris, also Parish Medical Officer, cited the problems involved in lodging complaints against one body to another when they were, in fact, composed of the same individuals. In this instance fault was found with the class of house built by the Parish Council and a complaint was made to the Sanitary Authority, a body which was, in effect, the Parish Council 'ex officio'.<sup>51</sup> A witness to the Poor Law Commission in 1910 reported that the provision of medical assistance to the poor would be improved if it was under the control and management of one body.<sup>52</sup>

Health and sanitary issues were widely reported to the Local Government Board in 1894, where both medical officers of health and sanitary inspectors reported the difficulties of changing ingrained practices, ‘Many of the outlying districts in the west and north country are practically isolated from the outside world; old time habits and customs in such places still survive; rigid observance to what has been the practice in past generations is their standard of sanitary surroundings to-day. Until very recently

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<sup>50</sup> *Dewar Evidence*, Q.17,419-20, p.362.

<sup>51</sup> *RC Poor Laws*, Evidence, 1910, p.550.

<sup>52</sup> *RC Poor Laws*, 1909, Minute of Evidence, 1910, p.801; Teachers, like doctors, could also have multiple roles; in 1899 the teacher in Abernyte was also Inspector and Collector of the Parish Council, Registrar, School Board Treasurer, School Board Officer and Heritor Clerk. Comparatively, their salaries were lower; the salary of successive teachers in Abernyte School, Perthshire, rose from £23 in 1877, £60 in 1882, £115 in 1899 and by 1907 was £140.

only a few had the courage to break through these old fashioned established customs, and inaugurate a better order of things.’<sup>53</sup>

The following extract from the annual report of the Sanitary Inspector in Skye, illustrates the scale and unremitting nature of the work carried out by sanitary inspectors, their relationship with the local doctor and the hazards they faced, including to their personal health. It also reveals the central governmental authorities’ increasing efforts to advance public health by raising the standard of hygiene and sanitation:

During the year, I travelled on foot in the discharge of my duties 2967 miles, much of the distance during the night and in stormy weather. I made 1758 inspections, disinfected 117 houses, 9 schoolhouses (some of them twice), and 2 meeting houses, inspected 2 fishing fleets, and five fishcuring stations, dealing with and affecting the removal of 5 nuisances from them.

On two different occasions, when dealing with infected houses, I was kept out of lodgings all night, without shelter during very inclement weather, walking about to keep up circulation till daylight, as I could not get on with disinfecting in the dark. I had twice to walk 25½ miles each time from infected premises to my own house during the night – once 31 miles, once 33 miles, and once from Flodigarry by Kilmaluag and Kilmuir to Portree, a distance upwards of 30 miles, much of the way in the night time, as I could not get a place to lodge in, the people being so afraid of infection; but if they had as much fear of the want of cleanliness in their houses and of their persons there would be fewer cases of infection to be afraid of.

The Sanitary Inspector also highlighted the lack of assistance available in outlying areas, even when it would have been required, which increased further the workload:

I had, along with Dr Dewar, District Medical Officer, to coffin the bodies of persons dying of infectious diseases; carrying the coffin between us to the cart and drive the cart to the graveyard; entered fever-stricken houses; stripped down all hangings; cleaned out furniture and rubbish; carried away and burned straw, hay, and litter; disinfected blankets, sheets, bedding, sacks, wool, and wearing apparel; carried fever patients from their beds to conveyances, drove same to hospital, carried them in and placed them on the bed. Had for several nights to lie on hard floor of anteroom of Hospital, as I would not be allowed by my neighbours to enter my own house. Had to act as porter and messenger at the Hospital during the occupancy by patients, as no person on any consideration could be got in the place to act. I cleaned out the beds, emptied tickings of all stuffing, burning the same,

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<sup>53</sup> *Extracts from reports for 1894, by County, District and Burgh Sanitary Officers, Appendix A, No. 24, p.118.*

disinfected and steeped blankets, sheets and ticking, and with the assistance of the patient's mother, washed them, attended to their drying and folding alone, as no woman would go near the work. I also received, conveyed to, carried in and fitted up the beds and furniture in the Hospital.

District Sanitary Inspectors in other places consider this sort of work *special*, for which another man should be in hand to attend to.<sup>54</sup>

The senior position of the County Medical Officers enabled effective lobbying to the County Councils for support in effecting change, both medical and sanitary. County Medical Officers and Sanitary Inspectors' journals, which they were required to submit monthly to Councils and which had to include an index of places visited, documents in some detail that much of their time was spent encouraging improvements in hygiene within the localities, with the aim of reducing the incidence and spread of disease.

An early entry relating to an outbreak of scarlet fever in Kilspindie records in detail the measures taken to isolate the patients and to prevent the spread to others. On July 23<sup>rd</sup> he received a telegraph from the local medical officer, Dr Howison, asking him to visit Durdie with him as the ploughman and cattleman's children were both infected with the disease. The incidence rose the next day,

Mr Hope, Nether Durdie, called to say that his servant and two children were down with scarlet fever. The children had been put into an upstairs room where they could be easily isolated - the servant however was in a room off the kitchen and isolation impossible. Telegraphed to Dr Howison to enquire if servant had scarlet fever and could she be removed. Received reply 'not decided, but very suspicious'. To set the matter at rest I visited the house in the afternoon and found that two children suffering from well-marked scarlet fever with very slight throat miseling. The servant however had a very severe scarletinal sore throat and no rash.<sup>55</sup>

The County Medical Officer uncovered the source of the infection, which arose from the servant having visited the ploughman's house at Balmyre, where the first case of scarlet fever occurred, where another two children and their mothers were suffering from the fever. The servant had tidied the house and hurried to milk the cows at Durdie, carrying the infection from Balmyre to Durdie. The servant was removed to Perth Royal Infirmary and the bedroom she had been in was closed till fumigated by

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<sup>54</sup> Extracts from reports for 1894, by County, District and Burgh Sanitary Officers, Appendix A, No. 24, pp.128-129.

<sup>55</sup> P&K Archive, CC1/9/1/1, *Medical Officer of Health Journals*, p.82.

the sanitary inspector. Only one death, 'the cattleman's boy' occurred during the outbreak<sup>56</sup> The County Medical Officer was also concerned regarding the lack of fever hospitals and an ambulance to transport infectious cases to the Infirmary. In 1892 Dr Graham was successful in his recommendation of expenditure of £125 for a small portable hospital for the treatment of smallpox patients.<sup>57</sup>

As well as demonstrating the advances in the knowledge and management of infectious diseases, which were taking place by the later nineteenth century, the journals demonstrate the communication networks which were being developed both within and outwith the county structures. The County Medical Officer was in regular contact with local medical officers and with the Sanitary Inspector, which was crucial in halting the spread of infectious disease. The importance of telegraphic communications, which reduced some of the travelling required, is also clear. County Medical Officers throughout the country were also in touch with each other, for example, for practical medical reasons, where infectious outbreaks straddled county borders or for administrative advice or knowledge. Dr Graham, for example, was in touch regularly with Dr Russell, County Medical Officer for Glasgow and with the County Medical Officer in Fife, with whom he sympathised about the difficulty of ensuring adequate returns from the Registrars, 'nearly one half of the Fife Registrars had refused to send returns'. Dr Graham had received the permission of the Registrar-General to obtain the information, in an effort to gain access to complete returns.<sup>58</sup>

By the end of the first decade of the twentieth century the public health and local government legislation had made some inroad into the severity of infectious disease. Parishes and subsequently county councils, integrated more refined medical and sanitation policies and procedures into their administrations.<sup>59</sup> Despite the progress made since 1845, the Departmental Committee's Report on the Poor Law Medical Services reported in 1904 that whereas medical relief arrangements in the Lowlands were 'fairly adequate', in the Highlands 'it (could) scarcely be said that medical relief afforded to the outdoor poor is as efficient as it ought to be'. It also stated that 'paupers [were] as a rule better off than the general population' so far as medical attendance

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<sup>56</sup> P&K Archive, CC1/9/1/1, *Medical Officer of Health Journals*, p.99.

<sup>57</sup> P&K Archive, CC1/3/1/8, County of Perth, *Second Annual report by the County Medical Officer*, 1892, p.7.

<sup>58</sup> P&K Archive, CC1/9/1/1, *Medical Officer of Health Journals*, pp.78, 81.

<sup>59</sup> The day-to-day implementation of the public health related legislation is detailed in parish and council minutes and MOH reports.

[was] concerned.<sup>60</sup> Thus little had changed. The implications of this for the non-pauper population of the Highlands were far-reaching. To provide for the non-pauper population more qualified doctors and nurses had to be attracted to the Highlands.

### **3.4 Conditions of employment in Highland districts**

In 1870, the testament of Dr Charles Park, parish doctor in Campbeltown, recorded household effects worth £160 16s, and a personal estate of £210 1s 6d. Debts due to him totalled £330 11s 6d, all from patients who were unable to pay the doctor's fees, ranging from £17 7s 6d to 10s 6d. Some were disputed and some were considered irrecoverable. The debt was valued at £100. The level of unpaid fees represent lost income to the doctor and his family, but also represent the inability to pay on the part of those individuals in the community.<sup>61</sup>

These and other factors, which were all documented in the Physicians' Enquiry, survived well into the twentieth century. They included low salaries, the necessity in most areas to supplement income from private practice and the difficulty many patients had in affording doctors' fees, illustrated above, security of tenure, availability of housing, arduous working conditions and professional isolation. The difficulties of saving for retirement was another pressing concern. The conditions of service influenced the numbers of doctors prepared to live and work in the Highlands and for those who did the reward could be penury in old age; superannuation, like holiday entitlement, was not provided to the highland doctor. Any improvements which had taken place in this period occurred within the existing structures, thus hindering the long-term development of effective medical services in the Highlands.

#### **I. Qualifications and professional development**

The quality of medical appointments in the Highlands was addressed by the Dewar Committee. Following the Medical Act of 1858, a qualification, approved by the General Medical Council, was required for admission to the Medical Register, and was necessary to provide indemnity insurance to doctors in the event of being sued. By the end of the nineteenth century 86% of doctors graduated with a university Bachelor of Medicine (M.B.) degree, as opposed to a diploma or licentiate from a

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<sup>60</sup> *Report on PLMS*, 1904, Vol. 1, Cd.2008, p.68.

<sup>61</sup> NAS, SC51/32/17, Dunoon Sheriff Court. Accessed from [scotlandpeople.gov.uk](http://scotlandpeople.gov.uk) (17/06/05)

college.<sup>62</sup> Concern was raised about new graduates, some acting as assistants, using their experience in the Highlands as a stepping stone to a more senior post.<sup>63</sup> They were also perceived as taking work from older general practitioners.<sup>64</sup> Witnesses to the Dewar Committee also expressed concern at the duties which could not be carried out by the parish doctors, including school inspections and aspects of dentistry, eyesight, tonsils or adenoids. The need for specialist centres was clearly stated.<sup>65</sup> The Medical Officer of Health for Sutherland reported that there was also a perception that older doctors simply bedded-down and could not provide a professional service or that poorer doctors would simply seek job security and a salary without the quantity of patients that would be experienced in southern urban centres. ‘You don’t want the riff-raff of the profession to go to these outlying places. It is there that the better men are required.’<sup>66</sup> There is little to corroborate this in the evidence to the enquiry and the same situation was found equally in other parts of the country. The County of Sutherland had no doctors who had graduated ‘50 years ago’, the implication being that younger doctors benefited from modern medical training and were more suited for varied rural office.<sup>67</sup>

In some areas, however, local conditions, such as the lack of a doctor’s house, prevented any continuity of service and led to a pragmatic approach to securing a doctor. In such cases any doctor, regardless of level of experience or type of qualification, was sought. For example, the parish of Eday in Orkney experienced six appointments between 1896 and 1903.<sup>68</sup> Women graduates, who found employment opportunities more difficult than male graduates to secure, and who sought experience in domiciliary practice, were employed by a number of Highland parish councils. Papa Westray in Orkney in particular employed a succession of women doctors, who were perceived as being more willing than men to live in lodgings, as a house was not available on the island. The lack of housing proved an almost insurmountable obstacle in the search for a doctor. Dr Janet Maclean, M.B. Ch.B., arrived in January 1904 and had resigned by June. The Parish Council reported to the Royal Commission on the

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<sup>62</sup> For a detailed description of the evolving system of medical qualifications see, M.W. Dupree and M.A. Crowther, *Profile of the medical profession*, p.219-222.

<sup>63</sup> *Dewar Evidence*, Q.1209-1210, p.41.

<sup>64</sup> *Dewar Evidence*, Q.1828, p.57.

<sup>65</sup> *Dewar Evidence*, Q.1786, p.55; Q. 8541-8543, p.184.

<sup>66</sup> *Dewar Evidence*, Q.7234, p.160.

<sup>67</sup> *Dewar Evidence*, Q. 8600-8606, p.185.

<sup>68</sup> *Return to the House of Commons on Parish Medical Officers’ vacancies by the Local Government Board*, 1903, p.3.

Poor Laws, the ‘principal grievance’ is that there was ‘no residence for our medical officers, the whole island being under Bond holders who state that they can neither grant ... a long lease or ground at a nominal rent.’ This was a situation with which they had been coping for nine years. In 1907 the Parish Council minutes report ‘The doctor had intimated that if something is not done immediately she will hand in her resignation within one month. We are in great fears that if the doctor’s house is not proceeded with at an early date we will lose her services.’ In March 1908 Dr Jennette Hargreave resigned and despite a deputation which asked her to withdraw it, she left the island in June. Over the next three years a number of advertisements, calling for a ‘qualified woman doctor’ attracted a number of applicants, none of whom stayed in their post. In 1925 the Parish Council were still fighting for a resident doctor on Papa Westray and were only successful in securing a doctor’s house in 1928.<sup>69</sup>

In such cases the type of qualification or level of experience was not under question; Papa Westray was not the only parish suffering a high turnover of doctors, as Table 3.6 demonstrates.

**Table 3.6 Turn-over (%) of general practitioners, in Orkney, Sutherland, and Selkirkshire and Haddington, 1900-1930**

County	1900-5	1905-10	1910-15	1915-20	1920-25	1925-30	Average
Orkney	47.83	36.36	39.13	35.00	36.84	34.62	38.3%
Sutherland	25.00	16.67	22.22	41.18	33.33	40.00	29.73%
Selkirkshire	30.77	40.00	27.59	37.04	48.00	40.00	37.23%
East Lothian	33.33	20.00	20.00	53.85	27.27	45.46	33.31%

**Source: Data compiled by Dr John Brims, from The Medical Directory, 1900-1910 (Five year samples).**

From 1900 to 1935 Orkney had an average of 22 doctors on the mainland and islands, the average percentage turnover being 38%. The figure fluctuated yearly from 47.83% in the early decade to 34.62 from 1925-30, the problem lessening as the century progressed. When compared to Sutherland and the two lowland rural counties of Selkirkshire and Haddington (East Lothian), the percentage turnover in doctors is not

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<sup>69</sup> CO6/11/2, Orkney Council Archive, Papa Westray Parish Council minutes.

significant.<sup>70</sup> The major difference, of course, was that the pool of doctors willing to move to the Highland counties was smaller. Any vacant position there, which was unfilled for any length of time, was crucial to the wellbeing of a remote community, as the example of Papa Westray illustrates. Elsewhere in Orkney, the parish of Rousay and Egilshay were without a doctor from March till October 1900, the vacancy finally extended to encompass the neighbouring parish doctor's remit. Eday experienced six vacancies during the years 1896 and 1903, one of which was vacant for two months. Although the other vacancies were immediately occupied, the parish clearly had little continuity in medical care. In the years 1896 to 1903 every Highland parish experienced at least one vacancy in the post of parochial medical officer, with the majority having more than one vacancy, for periods ranging from an immediate replacement to 15 months, in Evie and Rendall. Where difficulty was experienced doctors in adjoining parishes would attend the sick, or a *locum tenens* would be found as a temporary measure.<sup>71</sup> The severest problems were not confined to the most remote areas. The parish of Lochgoilhead and Kilmorack in Argyll had three vacancies of around two to three months during 1899, two doctors appointed in that time refusing the appointments as they were due to commence their duties.<sup>72</sup>

**Table 3.7 Number of doctors and the number with higher qualifications in Orkney, Sutherland, and Selkirkshire and Haddington, 1900, 1905, 1910**

County	Population (1900)	No of Doctors			No of doctors with higher degrees		
		1900	1905	1910	1900	1905	1910
Orkney	28,834	23	22	23	3	4	3
Sutherland	21,479	12	12	18	2	2	3
Selkirkshire	23,695	12	10	10	3	3	2
East Lothian (Haddington)	38,577	26	25	29	8	10	16

**Source: Data compiled by Dr John Brims, from The Medical Directory, 1900-1910 (Five year samples).**

Despite concerns that less well qualified doctors were employed in the Highlands, the table above shows that the proportion of doctors with higher degrees in rural parishes

<sup>70</sup> I am grateful to Dr John Brims, for his consent to use data from the *Medical Directory*, collected and collated by him. *Medical Directories*, 1900-1935.

<sup>71</sup> *Return to the House of Commons on Parish Medical Officers' vacancies*, 1903.

<sup>72</sup> *Return to the House of Commons on Parish Medical Officers' vacancies*, 1903, p.9.



in both the Highlands and Lowlands of Orkney, Sutherland and Selkirkshire in the Scottish Borders was not dissimilar between 1900 and 1910. The professional training of Dr Taylor of Yell (See Plate 2) illustrates that a conventional pathway through medical school was not an insurmountable obstacle and that doctors from less privileged backgrounds perhaps had an advantage when faced with the difficult working conditions and could empathise with the communities for which they were responsible.

Dr Taylor was a registered chemist and druggist prior to his medical training. He conducted extra mural classes and was a dispenser at Aberdeen Royal Infirmary to medical students - each student paid him £2 2/0 for the course. Having become interested in medicine from 'coming into daily contact with the medical students and doctors, [he] became imbued with a desire to become a doctor'. Using his income as a dispenser to fund his studies he graduated in 1890 from Marischal College with a Batchelor of Medicine (M.B.) and a Masters in Surgery (C.M.)<sup>73</sup> He was given an unfurnished house in Mid-Yell at a rental of £16 a year, a salary of £55 for Yell and £15 for Fetlar and later £5 a year as Medical officer of Health for the North Isles District Committee. This was in sharp contrast to the £250 a year he previously earned as a dispenser. Even before he met his wife on the island he resisted attempts to persuade him to take 'more remunerative' practices in the south, having become 'wedded ...to Shetland, its people and its beauties, and could not bring himself to leave it'. The qualities of determination and hard work, stood him in good stead for life in the Northern Isles, where a visit to many of his patients might involve several hours walk across the moors or a boat journey, in all weathers.

## **II. Salaries and lifestyle**

Within the Highlands and Islands the harshness of conditions varied according to location and degree of remoteness and for some of the medical profession those negative factors were compensated for by family connections in the Highlands, a lifestyle free from urban pressures and a loyalty to their community which family ties could engender.<sup>74</sup> When asked by the Dewar Committee 'Why do you remain in such an outlandish place where there are so many serious drawbacks', Dr Saxby, Parish Medical Officer in Baltasound, Unst, responded 'My father and grandfather practiced

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<sup>73</sup> H.P Taylor, *A Shetland Parish Doctor*, 1948, pp.9-20.

<sup>74</sup> *Dewar Report*, p.16.

here before me. I know the people and they have learned to know me, and it seems unfair to a community for a doctor to rise and leave them...' He also noted that while in the short term men moved on to other jobs, when family ties were made in a locality 'then it is difficult when a man is settled down in a place to shift'.<sup>75</sup> The lone general practitioner's duties could however also bring pressure to the family, calls from patients encroaching on family life. Mrs Ruth Sinclair, daughter and granddaughter of Orkney doctors recalled family trips being cancelled at the last minute as a call came in and the car was needed for a patient visit. 'as long as single practice doctors were there, they were on call'.<sup>76</sup> Dr Taylor, his colleague on the neighbouring island of Yell, followed this pattern. For others, the payment of salaries, which were inflated in relation to the number of paupers in a parish, was an inadequate inducement to work in the Highlands, and some areas experienced considerable difficulty in obtaining medical officers to fulfil the requirements of the MRG.<sup>77</sup>

At the turn of the century the level of income generated from the poor law varied widely from about £10-20 to £150-200, subsidised by fees from private practice.<sup>78</sup> In Argyll, closer to urban centres, poor law salaries ranged from £9 in Kilninver and Kilmelfort to £130 in Morvern and also in Lismore and Appin. In Sutherland poor law salaries ranged from £30 in Golspie to £190 in Assynt. In the northern islands salaries, from both private practice and the poor law, were generally lower; £12 in Bressay with a maximum of £58 in Delting.<sup>79</sup> In the parish of Fortingall in Highland Perthshire the medical officer appointed in 1881 was paid an annual salary of £15 to attend and provide medicines free of charge to the poor of the district (medicines provided to the poor of other parishes was to be charged for) when called upon by the Inspector; to visit and record in the visiting book lunatics resident in the parish every three months; to issue lunatic certificates for entry to the asylum and to make sick returns to the parochial board.<sup>80</sup>

In remoter areas the parish salary often appeared large in relation to the number of paupers, the provision of a substantial salary necessary to obtain a resident doctor. For example, the amount spent on medical relief in the parish of Barvas, Lewis in 1906

<sup>75</sup> *Dewar Evidence*, Q.7227-7231, p.160.

<sup>76</sup> Orkney Library Sound Archive, 104, Mrs Ruth Sinclair (2).

<sup>77</sup> *Dewar Report*, pp.32-33.

<sup>78</sup> *Report on PLMS*, 1904, Minutes of Evidence, Cd. 2022, Q.5046, p.173.

<sup>79</sup> *Return to the House of Commons relating to Parish Medical Officers (Scotland)*, London, 1905, pp.6, 8, 54, 56.

<sup>80</sup> P&K Archives, CC1/7/14/1, Parochial Board minutes, Fortingall, 1881.

was £210, which represented 13.61% of Poor Relief expenditure. That level of expenditure was 'on account of the substantial salary required to retain a resident medical officer'.<sup>81</sup> Likewise, in Lochs a greater proportion of poor law expenditure was spent on medical relief, primarily to provide a salary high enough to induce a resident doctor.<sup>82</sup> The medical officer on Colonsay was employed ostensibly to treat eight paupers.<sup>83</sup> The circumstances on Colonsay (with a population of 273) can be contrasted with conditions in the parish of Lochbroom, Ross and Cromarty. Lochbroom covered an area of 260,000 acres, had 3,200 of a population, 200 paupers and one medical officer who was paid a total of £125, which included payments as Vaccinator and Lunacy Officer.<sup>84</sup> In this parish, though medical provision was clearly inadequate, the low density and scattered nature of the population did not provide sufficient employment for another doctor, nor were parish funds available to provide an increased salary. Doctors did query what their salary covered; in 1911 a parish medical officer asked the parish council whether he could charge a fee for carrying out an operation to remove adenoids, which was refused on the basis that any operation not requiring the assistance of another doctor was included in the medical officer's salary. Had chloroform (and the assistance of another doctor) been required he would have been entitled to reimbursement of the cost by the council.<sup>85</sup>

Where a need for greater medical provision existed without sufficient work for a doctor the employment of a trained district nurse was an alternative, as in North Ronaldsay where a Jubilee nurse was resident on the island, the nearest doctor on the neighbouring island of Sanday.<sup>86</sup> The following table indicates the variation in levels of salaries of medical officers in the parishes of one Highland county for the year 1902.

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<sup>81</sup> *Report on Rates*, Outer Hebrides, 1906, p.lvii.

<sup>82</sup> *Report on Rates*, Outer Hebrides, 1906, p.lvii.

<sup>83</sup> *Dewar Report*, p.19.

<sup>84</sup> *Report on PLMS*, 1904, p.70; *Return to the House of Commons relating to Parish Medical Officers (Scotland)*, London, 1905, p.9.

<sup>85</sup> *The Poor Law and Local Government Magazine*, Digest of opinions of the LGB in Report of 2011, 1913, Vol.XX111, No.1, January, pp.1-2.

<sup>86</sup> *Report on PLMS*, 1904, Minute of Evidence, p.174.

**Table 3.8 Salaries of Caithness Medical Officers in 1902**

Parish	Total Salary including Lunacy and Vaccination Salaries		
	£	s	d
Bower	13	0	0
Canisbay	58	2	0
Dunnet	30	0	0
Halkirk	70	0	0
Latheron	140	0	0
Olrig	50	0	0
Reay	25	0	0
Thurso	50	0	0
Watton	14	0	0
Wick	144	0	0

**Source:** *Parish Medical Officers (Scotland), House Of Commons, 1905, 190.*

It is clear from the preceding table, which reveals the low level of parochial salaries in some parishes, that the ability to supplement the doctors' salary by private fees and supplementary posts, was vital in determining both the ability of a parish to hire doctors, and in establishing their standard of living. It also indicates that in some parishes, such as Bower and Watten, it was essential to supplement salaries, and that in those parishes at least, remuneration from public bodies was not the doctors' main source of income. In reality however, in many parishes almost the whole professional income of the doctor was his salary from the parish, fees from attendance of non-pauper poor patients being insignificant.

### **III. Security of tenure, pensions and lack of holidays**

As well as the difficulty of relatively low salaries parochial medical officers employed for the treatment of outdoor poor did not have security of tenure, which was a long-standing grievance. Neither did they have any paid holiday provision. Whereas the County Medical Officer of Health, the poor-house Medical Officer, the Sanitary Inspector and the Inspector of the Poor could be dismissed only by, or with the sanction of the Board of Supervision and later the Local Government Board, the parish council had absolute powers of dismissal over the parish medical officer, a power which was used indiscriminately by some parish councils, a fact noted by the

Dewar Enquiry, 'They cannot dismiss a Poor Inspector for any triviality. They can dismiss a medical officer at will.'<sup>87</sup>

Doctors in existing posts were also subject to bullying and faced dismissal with no recourse. A case in Clyne Parish regarding a complaint to the Parish Council on the non-attendance of the doctor to a child as a private patient resulted in the summary dismissal of the doctor, despite a protestation that his private practice, which most rural doctors depended on to give them an adequate salary, was not the concern of the council. Correspondence to the *BMJ* reported '...it was moved, and unanimously agreed, that the medical officer for the parish should be asked "to tender his resignation at once or within three days after notice" '. If no reason was given for a dismissal the doctors, with no security of tenure, had no right of appeal.<sup>88</sup> Private practice was a regularly reported bone of contention between doctors and parish councils. One parish council, for example, required the doctor to make fixed fortnightly visits to distant parts of the parish at his own expense, whether or not there were sick paupers, and to cover the cost of medicines and medical appliances. Ostensibly for the benefit of the paupers the reported reason was 'for the benefit of ratepayers resident in such distant parts, and who thereby expect to receive cheaper and more conveniently the professional services of the medical officer. Should the medical officer refuse his services to such when on these fixed visits these ratepayers would immediately petition the parish council to "dismiss the doctor," and the parish council still have the right to do so under the Act in Scotland.'<sup>89</sup>

Instances arose of doctors' positions 'made so unbearable he is glad to resign '. The following return shows the number of medical officers dismissed between 1895 and 1901 and the cases in which a cause was assigned for the dismissal.

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<sup>87</sup> *Dewar Evidence*, p.28, Q.816; p.244, Q.11,525.

<sup>88</sup> *BMJ*, March 15, 1902, p.664.

<sup>89</sup> *BMJ*, March 15, 1902, p.664

**Table 3.9 Return of Medical Officers dismissed by Parish Councils since 15th May, 1895**

County and Parish	No. of Medical Officers Dismissed	Date	Whether a Cause for Dismissal was Assigned
<u>ARGYLL</u>			
Kinfinichen	1	1897	No
<u>CAITHNESS</u>			
Halkirk	1	1896	No
<u>INVERNESS</u>			
Ardersier	1	1902	Yes
Barra	1	1898	No
Croy	1	1902	Yes
Petty	1	1902	Yes
S.Uist	1	1898	Yes
<u>ORKNEY and SHETLAND</u>			
Eday	1	1899	Yes
Evie	1	1898	No
Rousay	1	1900	No
<u>ROSS-SHIRE</u>			
Kincardine	1	1896	No
Uig	1	1899	No
<u>SUTHERLAND</u>			
Durness	1	1898	No
Kildoran	1	1899	No
Loth	1	1899	No

**Source: Return Showing the number of Medical Officers Dismissed by Parish Councils in each crofting County during each of the Seven Years 1895-1901, Name of the Parish Council and the cases in which a cause of dismissal was assigned. 1902, (349), LXXXVIII, 571.**

Between 1855 and 1902 one hundred and thirty nine complaints were received by the Board of Supervision, (from 1895 dismissals required the approval of the Local Government Board). Eighty-eight were cited as being unfounded, in twenty-eight cases the medical officer was censured, twelve medical officers were allowed to resign and eleven were dismissed. A witness to the Dewar Committee referring to the return expanded on the reasons for dismissal.<sup>90</sup> Accordingly, the dismissal from Argyll appeared to be unjustifiable. In another case in Inverness the doctor had been paralysed for a number of months, was requested to resign and when he would not do so was dismissed. That particular doctor was also medical officer for two other

<sup>90</sup> *Dewar Evidence*, Q.662, p.22.

parishes where dismissals were cited, therefore only three dismissals occurred in Inverness.

The documentation of one dismissal case illustrates both the difficulties that doctors could face and also the loyalty some communities demonstrated to their doctor.<sup>91</sup> Dr Lachlan Grant, parochial medical officer at Ballachulish and Kinlochleven, and holding radical political views, was also the medical officer for the Ballachullish slate quarries.<sup>92</sup> Grant campaigned widely for economic and social development in the Highlands and in his early 1930s publication he called for 'A New Deal for the Highlands'. He was closely involved in the establishment of the Highland Development League in 1936, modelled on Roosevelt's Tennessee Valley Authority. In 1902, after two years in post, he was dismissed 'without any reason being alleged or any explanation given' from both his parish and quarry positions. Spurious reasons were provided by the company, one was jealousy from the quarry manager, MacColl, vying for 'local power, position and influence' against the popular, outspoken doctor. Unparalleled community support ensued – a public meeting had to be held in the square 'the Hall was not nearly large enough to accommodate the numbers that thronged together' – which spread throughout Scotland.<sup>93</sup> Keir Hardie spoke in his support at a packed meeting in Ballachullish. A lock-out closed the quarry for over a year, illustrating the strength of the local support and outrage his dismissal had caused, at which point the company eventually capitulated and re-instated Dr Grant.

This example has wider issues than the dismissal of the doctor. The strength of the support for him illustrates firstly the close ties doctors could develop with their communities through participation in local groups and by being closely involved in local issues. Dr Grant was president of the local shinty team, a champion of all things Gaelic and participated in 'Gaelic cultural evenings', within the auto-didactic bilingual community.<sup>94</sup> An immensely popular man, brought up in the area and who had previously worked in the Gesto Hospital in Skye, he was a stalwart supporter of 'new liberalism' – chairman of the Argyllshire Liberal Association – and public speaker in

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<sup>91</sup> The papers of Dr Lachlan Grant are held by the National Library of Scotland, NLS, Acc.12187, Dr Lachlan Grant MD. Further information can be found in, N. Grant, *Custom and Conflict in 'The Land of the Gael': Ballachulish, 1900-1910*, London, 2007. I am grateful to my colleague Alan Bell who brought this book to my attention and to Neville Grant for sight of the unpublished manuscript.

<sup>92</sup> L. Grant, *A New Deal for the Highlands*, (place of publication not available), 1935.

<sup>93</sup> NLS, Acc. 12187, Dr Lachlan Grant MD, Vol.1, 1902, p.2.

<sup>94</sup> Grant, *Custom and Conflict* mss., p.42.

support of social and medical reform and in a greater role for the state in improving health.<sup>95</sup>

Secondly, he represented all that was positive and sought after in a Highland doctor. He had impeccable medical qualifications and a clear vision about how medical services and the situation of Highland medical officers could be improved. Unlike many doctors he was qualified to provide specialist services, including ophthalmic work. His evidence to the Dewar Committee was startling in its depth and volume; he presented a scheme for a state service for 'all the people', which must have taken some weeks to prepare and mirrored many of the functions of the future Highlands and Islands Medical Service.<sup>96</sup>

Thirdly, the inability of the parish council to prevent the parochial medical officer from being dismissed by a private company demonstrates both the lack of power of the local medical committee and the powerlessness of the doctor to defend himself. The role of the Local Government Board is also called into question; it provided no support and he was reliant on the sustained efforts and opposition of the community for the re-instatement of his posts.

One instance, however, is documented in which the medical officer of Barvas was protected by a clause in his agreement with the Parish Council, which stated that his contract could not be terminated without the consent of the Local Government Board. His father, the previous doctor, had no such agreement. He estimated that up to 50-60% of his general practice fees were not paid. His salary comprised £160 as medical officer, 14 guineas each from the School Board and Northern Lighthouse Board.<sup>97</sup>

In 1900 a Parish Medical Officer in Orkney was dismissed when he resigned his connection with the Medical Benefit Association, a medical club. Medical clubs were a point of contention throughout the Highlands and Islands. Doctors complained that club fees were not paid on a regular basis, thus limiting their income. In 1917 a locum doctor in Strath parish, Skye, complained to the Local Government Board that when the locum tenancy expired he was appointed as medical officer only on the condition that he agreed to work for the Strath Medical Club. The Parish Council were thus attempting to dictate the conditions of the private practice of the parish, an attitude in

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<sup>95</sup> NLS, Acc. 12187, Dr Lachlan Grant MD, Vol. 4, 1908-1913, p.43.

<sup>96</sup> *Dewar Evidence*, Q.19,718, pp.393-5.

<sup>97</sup> *Dewar Evidence*, Q.12,262-3, p.257.



which they persisted despite a reminder from the Local Government Board (replaced the Board of Supervision in 1894) that it was *ultra vires* of them to attach to the appointment of a medical officer conditions affecting private practice. This position was justified by an expression of concern regarding the provision of medical aid for the non-pauper population.<sup>98</sup> This reason was frequently cited in the argument against providing parish medical officers with security of tenure, for example,

the rate-payers in the parish would have no guarantee that the doctor would attend ordinary cases. When called on he might take up the position that he was only appointed as medical officer for the paupers. He could also fix a scale which would be prohibitive to the poorer rate-payers who would be unable through poverty to obtain the services of the doctor from a neighbouring parish.<sup>99</sup>

Parish Councils being composed predominantly of the local 'professional class' wielded much power within their own locality and resented any outside interference. The strength of this feeling is indicated by the actions in 1925 of the Strath Parish Council which had a similar confrontation with the parochial medical officer, the entire body resigning eventually *en masse* in protest, refusing to capitulate to the instructions of the Board of Health, but meanwhile making conditions in the parish very uncomfortable for the doctor in question.<sup>100</sup>

The previous points demonstrate the vulnerable position of parochial medical officers in terms of security of tenure. Moreover, evidence to the Dewar Enquiry suggested that disagreements were frequently undocumented as they were seldom reported to the Local Government Board. Such incidents, however, were often reported in the press. Witnesses to the Dewar Enquiry stated knowledge of disputes resulting in the resignation of the medical officer which had never come to the Board's notice.<sup>101</sup>

The lack of paid holidays and provision for old age did not lead to such incidents but were a constant source of grievance to doctors. They were required to pay for a *locum tenens* out of their income if they needed a break and many were forced to work into old age due to their inability to save for their retirement. In 1907 Dr Taylor of Yell, called as a witness to the Royal Commission on the Poor Law in Edinburgh, described the trip as 'a jolly holiday, lasting exactly ten days', having not had a day off in the

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<sup>98</sup> NRS, HH65/1.

<sup>99</sup> *Report on PLMS*, 1904, Minutes of Evidence, Q.5023, p.173.

<sup>100</sup> NRS, HH65/1.

<sup>101</sup> *Dewar Report*, p.28.

past six years. In addition to first class travel, a free *locum* and a daily subvention, he had the opportunity to meet professional colleagues from other Highland parishes with whom he 'had correspondence regarding Fixity of Tenure, Houses for Doctors, Annual Holiday and Superannuation'. He noted that many doctors had not had a holiday in years; one over 70 years of age, who 'could not retire else he would have starved.'<sup>102</sup> In addition to the need for a break from the often arduous work the Dewar Report raised concern regarding the need for doctors to be able to keep their professional skills up to date by attendance at post-courses.<sup>103</sup>

#### IV. Housing

Insecurity of tenure, therefore, can be cited as one factor in the rapid turnover of doctors in some areas, although the degree of isolation and the other points already raised were also factors contributing to medical officers vacating their appointments. Another important source of dissatisfaction of Highland doctors which influenced the level of medical service was the provision and standard of housing for parochial medical officers. The Royal Commission on the Poor Law reported in 1909 'that in certain country districts better arrangements for medical relief might be secured if power were given to provide a dwelling house for the Medical officer'.<sup>104</sup> They recommended that parish councils should have the power to do so, subject to the sanction of the Local Government Board. A previous Parliamentary Commission reporting in 1904 cited this factor 'for the absence of candidates and the reluctance to accept employment in those parishes'.<sup>105</sup> The failure to provide adequate housing was attributed as one cause of medical officers frequently leaving a certain parish. In many parishes a house was not available, in others 'the only accommodation was considered unsuitable'.<sup>106</sup> One advantage of hiring doctors with local ties was the potential for housing them with relatives when housing was not otherwise available. The first doctor to be appointed on the island of Staffa for 10 years was the son of a crofter who resided with his father, a doctor's house not being available. He was paid a salary of £75, which did not include medicines. The previous incumbent left the island as he was 'not comfortable in the place'.<sup>107</sup> The island of Bressay relied on doctors from

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<sup>102</sup> H.P. Taylor, *Shetland Parish Doctor*, pp.68-9.

<sup>103</sup> *Dewar Report*, p.16.

<sup>104</sup> *Royal Commission on the Poor Laws*, 1909, p.160.

<sup>105</sup> *Report on PLMS*. 1904, p.70.

<sup>106</sup> *Report on PLMS*. 1904, Minute of Evidence, Q.5023, p.173.

<sup>107</sup> *Dewar Evidence*, Q.16242-16248, p.336.

Lerwick. The lack of a house prevented the employment of a doctor for the island. 'The doctor would not live in a crofter's house, and he would need as much money for a house as he would need for his salary.'<sup>108</sup> In numerous letters to the Local Government Board parish councils sought advice on and finance for, the provision of houses for Parish Medical Officers. For example, in 1900 the Parish Council of Kincardine in Ross sought permission to apply the poor rates for such a purpose, as they were experiencing 'great difficulty in procuring a suitable medical officer for the parish for want of a dwelling house'. The only lodgings available were suitable only for a single man and they feared they would lose an experienced doctor prepared to take the position if a house could be provided.<sup>109</sup> Similar circumstances existed in 1903 in the parish of Sleat in Skye where the incumbent doctor 'otherwise satisfied' was threatening to leave as there was no house for him.<sup>110</sup> They were not isolated incidents: Between 1897 and 1915 Papa Westray had a succession of fifteen resident doctors, due mainly to the lack of suitable accommodation.<sup>111</sup>

## **V. Private practice and the Poor Law**

It can be seen clearly that despite the increase in the provision of medical services in the Highlands and Islands from 1845, that many problems still existed and that great frustration and some resentment was experienced within the medical profession. The founding of the Scottish Poor Law Medical Officers Association in 1895, formed to raise the status of Poor Law Medical Officers and to provide a channel through which defects in the system could be identified and dealt with, indicates this concern. In its early years it campaigned vigorously for the improvement of the terms of service of its members, primarily in order to bring them into line with their counterparts in England and Ireland, who had greater security of tenure.<sup>112</sup>

The founding of the association and information contained in Parliamentary Reports reveals how medical practitioners perceived parish employment. Such employment was not regarded as a stigma, as it was in England. In the Highlands most parishes were single-practice areas and in such districts all medical practitioners were parish doctors. Although it is not clear from the available information how widespread this

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<sup>108</sup> *Dewar Evidence*, Q.7111-7114, p.158.

<sup>109</sup> *Report on PLMS.*, 1904, App.LXIV, p.285.

<sup>110</sup> *Report on PLMS.*, 1904, App.LXIV, p.285.

<sup>111</sup> R. Taylor, 'Primary health care in Orkney' in *Northern Scotland*, p.118.

<sup>112</sup> Information from D. Dow, former Greater Glasgow Health Board Archivist.

was, some evidence suggests that due to the difficulty of obtaining payment, some doctors were cautious about treating patients privately. The following circular to private patients issued by a Highland doctor illustrates this:

**Circular to Private patients (retyped from report)**

Dr.\_\_\_\_ respectfully requests your attention to the following:-

CONSULTING HOURS- 9to10 a.m.; 2to3 p.m.; 7to8 p.m.

CONFINEMENTS- Dr.\_\_\_\_ cannot undertake to attend any confinement for which his services have not been pre-engaged for at least a month.

HIRES Hires and also driver's fees must be prepaid by patient's messenger. NIGHT

VISITS- For visits between the hours of 8pm. and 8am. a double fee will be charged.

**PRIVATE PRACTICE**

Owing to the unremunerative nature of the private practice in this parish, but more especially in consequence of one or two individuals- through ignorance- having made mis-representations regarding the doctor's duties, Dr\_\_\_\_ regrets that he is under the necessity of making the following statements, vis:- 1st. Dr.\_\_\_\_ 's professional services are engaged and paid for by the Parish Council \_\_\_\_\_ , for his attendance on and for medicines supplied by him to sick paupers only.

2nd. Dr.\_\_\_\_ is not paid by the Council for professional services to any private patient, nor has the Parish Council any jurisdiction whatever over his private practice. He may - should he so desire - decline to attend any private, whether payment be offered to him or not.

3rd. Should any person - who is not a pauper - be unable to pay the doctor the moderate and graduated fees charged, that person's proper course is to apply to the Parish Council - through the medium of the Inspector of Poor - for parochial (medical) relief.

Please keep this circular for reference.

**Source: Departmental Committee On Poor Law Medical Relief (Scotland), Appendices and Index to Evidence, Vol. 11, 1904, Cd.2022, pp.255-256.**

The refusal of private practice was therefore feared as a consequence of parish medical officers receiving security of tenure. One possible response of the doctor to discontent with conditions of employment in the Highlands and Islands, was simply to resign and find employment elsewhere. In certain districts, particularly on the smaller islands and more isolated parishes, the office of parochial medical officer was vacant for lengthy periods during which no local medical provision existed. Where this

occurred, locums from neighbouring parishes were generally provided, so that the parish council fulfilled its statutory duty to provide medical relief for the registered poor. In the unlikely event that no paupers lived in a parish it is feasible that there would have been no medical provision. Table 3.10 indicates the length of time a sample of parishes in Highland counties had no resident medical officer.

**Table 3.10 Return of Parishes in Highland Counties in which the Office of Resident Parochial Medical Officer was Vacant in the last Seven Years, 1903, stating (a) Name of Parish (b) Number of Times a Vacancy has Occurred (c) Length of Time Office has been Vacant in each case.**

County and Parish	No. of times a vacancy has occurred within last 7 years.	Length of time Office was Vacant.	
		Mths.	Days.
<b>Orkney</b>			
Birsay & Harray	Once	0	12
Evie & Rendall	Twice	1. 1	57
		2. 0	7
Papa Westray Resident M.O. first appointed 1897, since then	Three times	1. 4	0
		2. 5	0
		3. 1	0
Walls & Flotta	Three times	1. 6	0
		2. 3	0
		3. 6	0
<b>Caithness</b>			
Halkirk	Once	5	0
Latheron	Twice	1. 2	0
		2. 4	0
Clyne	Twice	1. 3	0
		2. Did not remain at any time vacant	
<b>Ross &amp; Cromarty</b>			
Alness	Once	1. 5	0
Lochbroom	Once	2(a locum tenens acted )	
Lochs	Twice	1. 1	7
		2. 2	6
<b>Inverness</b>			
Ardersier	Once		1
<b>Harris</b>	Once		7
		(but supplied a substitute)	
<b>Small Isles</b>	Twice	1 May till July 1898	
		2 May till Nov. 1902	
<b>Argyll</b>			
Kilmuir	Four Times	1. 1	0
		2.(Locum tenens appointed)	
		3. "	
		4. 5	

**Source: *Parochial Medical Officers (Scotland). Return To House of Commons, 1903.***

Of course the provision of medical services was not fully reliant on public bodies such as the Poor Law. Charitable bodies and landowners in some areas of the Highlands funded nursing services and medical relief, thus continuing their traditional paternalistic role in the Highlands. For example, Sir Samuel Scott of Harris formed an agreement with the doctor to finance attendance on all bona fide residents on his North Harris estate thus assuring the local population of medical attendance and there are many instances of such assistance in Highland Perthshire. Often of course, the greatest concern was to ensure the presence of a medical practitioner in the district for their own benefit.

In 1911 the demand in Shetland for better hospital accommodation was taken up by leading members of the fish trade. They produced £400 to form the basis of the £1,000 required to provide the required accommodation in the Gilbert Bain Hospital. The remainder was raised by levying a small tax on shore workers and fishermen.<sup>113</sup> The Royal Commission on the Poor Laws had noted that medical treatment in the Balfour Hospital, provided by an endowment supplemented by voluntary contributions, was the only source of medical relief given in Kirkwall. Board, nursing and medicines were given free to those unable to pay and patients were accepted on the recommendation of a medical practitioner.<sup>114</sup>

Where local hospitals did exist, established by philanthropic benevolence, such as Gesto Hospital, Skye, the ability to attract doctors could be affected by the manner in which the hospital was managed. The medical officer for the hospital was required to treat crofters in their homes, failure to do so resulting in complaints to the trustees. As a fee was often not forthcoming the doctor's income was reduced. That scenario was reported in the BMJ in 1911.<sup>115</sup>

The Highlands were not alone in experiencing these issues in remote rural areas. In the British colonies administrations grappled with similar problems. New Zealand hospitals administered both indoor and outdoor relief and the poor were expected to pay when possible but in reality the hospitals were described as 'benefit societies'

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<sup>113</sup> *The Scotsman*, Jan.1, 1912, p.12.

<sup>114</sup> *RC Poor Laws*, Evidence, 1910.

<sup>115</sup> J.C. & S.J. Leslie, *The Hospitals of Skye*, Avoch, 2011, pp.18-19.

insuring for an annual sum of £1 6s, free outdoor medical treatment to families. It was estimated that the cost of free medical care was equivalent to a tax of 2s 7d per head of population.<sup>116</sup>

Before the passage of the Poor Law (Amendment) Act such action was considered counter to the self-help ethic, restricting the liberty of the individual. In 1848, however, the MRG was announced with no visible dissent, indicating, even in that early period, a gradual public acceptance of state involvement in issues previously considered to be outside its remit, and a growing awareness and indeed acceptance, that poverty was not always self-inflicted. Although the term 'state welfare' would not have been recognised at that time the grant represents an early, albeit limited, example of it.

The overall level of medical provision by 1912 was fragmented and tenuous; problems related to the appointment of medical personnel, such as inadequate housing, insecurity of tenure, isolation and low incomes were still prevalent at the beginning of the twentieth century. This was clearly recorded in evidence given to the Royal Commission on the Poor Laws in 1909. Medical provision for the majority of the Highland population was totally reliant on doctors employed to carry out parochial medical relief, and for those living in isolated districts was expensive. The high proportions of uncertified deaths in the Highlands bears this out and indicates an unwillingness to call the doctor; in the case of the elderly a prevalent view was that a doctor could serve little purpose when old age was the cause of illness 'it is just old age that that has caused the death'.<sup>117</sup> That attitude was not through any mistrust of the medical profession but through an inability to pay, 'a reluctance to incur expense'.<sup>118</sup> The large increase in doctors' workloads after the establishment of the Highlands and Islands Medical Service in 1913 confirms this. While communications and transport improvements made it easier for doctors to carry out their work, evidence shows clearly that doctors often gave their services when they knew that payment was unlikely. Any change occurred within the existing framework of the Poor Law. By 1912 conditions in the Highlands and Islands were perceived as being so bad that the

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<sup>116</sup> *Royal Commission on the Poor Laws and Relief of Distress*, Appendix Volume XXXIII, Foreign and Colonial systems of Poor Relief, Cd. 5441, 1910, London, pp.157-8.

<sup>117</sup> *Dewar Evidence*, Q.5098-5101, p.123.

<sup>118</sup> *Dewar Evidence*, Q.5909, p.138.

British Medical Association tried to prevent men taking up posts in the Highlands by posting counter advertisements for positions.<sup>119</sup>

The Dewar Committee, set up in 1912 to examine medical services in the Highlands, was the first body to suggest institutional change, financed by public money, to benefit the poorer (non-pauperised) sections of the community. Within the context of 'New Liberalism' and the National Insurance Act the Dewar Commission radically, and uniquely within the United Kingdom, fundamentally altered the structure of medical services in the Highland counties.

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<sup>119</sup> *Dewar Evidence*, Q 2688-2692, p.78.



## CHAPTER FOUR

### THE BACKGROUND TO THE ESTABLISHMENT OF THE DEWAR ENQUIRY

This chapter will examine the factors which led to the establishment of the Dewar Enquiry.<sup>1</sup> The Committee was established on 11 July 1912 by the Chancellor of the Exchequer, Lloyd George, under the Chairmanship of Sir John Dewar, MP for Inverness-shire. The report was published on 24 December 1912 and the accompanying minutes of evidence during 1913.

The Committee comprised - in addition to the Chair of the Enquiry, John Dewar - nine individuals, all with local or specialist knowledge of the Highlands, or expertise in their field. Established within the context of the ability to fulfil the requirements of the National Health Insurance Act in the Highlands, it was given the remit:

to consider how far the provision of medical attendance in districts situated in the Highlands and Islands of Scotland is inadequate, and to advise as to the best method of securing a satisfactory medical service therein, regard being had to the duties and responsibilities of the several public authorities operating in such districts.<sup>2</sup>

The enquiry's report and accompanying evidence and appendices included details of many aspects of Highland life, culture and economy, as well its primary purpose, to investigate medical services. It provides a detailed and extensive snapshot of everyday life in the Highlands during this transitional period in Highland history when popular unrest was being commuted into a public acknowledgement of the Highlands '...as a special case, requiring the development of policies, the creation of agencies and the supply of a subsidy not thought appropriate in the rest of the country'.<sup>3</sup>

The previous chapter's assessment of social and medical conditions in the second half of the nineteenth and early twentieth centuries outlined the establishment and development of the parochial medical service upon which most of the population of the Highlands relied for medical care. Centrally overseen by the Board of

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<sup>1</sup> The Highlands and Islands Medical Service Committee was referred to as the Dewar Committee, after the Chair, Sir John A Dewar, M.P. for Inverness-shire.

<sup>2</sup> *Report of the Highlands and Islands Medical Service Committee*, Minute of Appointment, 11 July 1912, Cd.6559.

<sup>3</sup> Devine, *Clanship to Crofter's War*, p.239.

Supervision, and from 1894 the Scottish Local Government Board, the parochial medical service was managed by local authorities with many local and regional variations. Developing concurrently, the centrally-funded public health service, intricately connected with the political and social ideology of ‘new liberalism’, was maintained and developed by branches of central government. Throughout the second half of the nineteenth and first decade of the twentieth centuries the level of pauperism was increasing and concern about the state of health of the nation was evident during government debates, the press and in professional medical journals.<sup>4</sup> Numerous public enquiries were established which sought to examine the social and economic conditions of the Highland population. All revealed its vulnerability to economic instability and disease and increasingly viewed the Highlands as a region requiring special attention.<sup>5</sup> The declining proportion of the MRG allocated to the Highlands, which almost halved in the years preceding the enquiry, placed additional financial strain on local authorities in the north and west, and on the services they provided.<sup>6</sup>

The Highlands and Islands Medical Services Committee, therefore, was not distinctive in focusing on the Highlands, but it was unique in having as its primary focus medical provision and related conditions at the local level, and in the breadth of the information it collected, which covered all aspects of life in the designated crofting counties.<sup>7</sup>

Following a robust and intensive enquiry and report its recommendations were unanimously accepted by the government. The Highlands and the Islands (Medical Service) Grant Act was passed on 15 August 1913 as a result of the recommendations

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<sup>4</sup> Concern was expressed in Parliament, the *Glasgow Herald*, the *Scotsman* and in many regional Highland newspapers such as the *Shetland Times*. The *BMJ* is undoubtedly the best source for professional medical opinion at this time. The online availability of many of these sources, including *Hansard*, greatly facilitates the ability to gain a more comprehensive understanding of the concerns and opinions being expressed than was previously possible.

<sup>5</sup> *Report of the Royal Commission on the Poor Laws (Scotland)* Cd.4922, 1909; *Report of the Departmental Committee enquiry into the system of Poor Law Medical Relief and Management of Poorhouses*, Cd.2008, 1904, and Minutes of Evidence and Appendices, Cd.2002, 1904, *Reports to the Local Government Board for Scotland on the Burden of the Existing Rates and the General Financial Position of the Outer Hebrides*, Cd.3014, 1906; *Condition of the Cottar Population in the Lews*, Cd.5265, 1888; *Social Condition of the People of Lewis in 1901 as compared with Twenty Years Ago*, HMSO, 1902; *Evidence to the Napier Commission*, C.3980, 1884.

<sup>6</sup> The majority of the most heavily rated Highland parishes in 1905-6 were in the Western Isles, North Skye and mainland Shetland, *Royal Commission on Poor Laws and Relief of Distress*, Appendix CLIX (C) No.5.

<sup>7</sup> The remit of the Departmental Committee on Poor Law Medical Relief in Scotland, which reported in 1904, covered the whole of Scotland and did not directly address private practice.

of the Committee, less than a year after the Dewar Committee presented its comprehensive report to parliament.

The reasons for the establishment of the Dewar Committee have not previously been examined in detail. The historiography to date focuses primarily on one aspect, the National Insurance Act of 1911. Contemporary and other early commentators including Day, the Marchioness of Tulliebardine, Comrie and Ferguson all, with little discussion, attributed the establishment of the Dewar Committee to the National Insurance Act. The Marchioness, a member of the Dewar Committee, however, did appreciate that the remit of the enquiry had its precedents, citing in her memoirs the 1904 Royal Commission on the Poor Law, ‘the crying need for a more complete system of medical attendance in many areas of the north.’ According to Ferguson, who also cited the National Insurance Act as the prime cause, stated uncritically, ‘In Highland Counties the problem of how to attract skilled medical men was not finally solved, until, following the Dewar report of 1912, a subsidised service, the Highlands and Islands Medical Service, was introduced...’.<sup>8</sup>

Later writers, including Hamilton, Jenkinson, Dingwall and McCrae also cite the National Insurance Act as the main impetus for the Dewar enquiry. Hamilton refers to the National Insurance Act as representing a culmination of a number of enquiries, including the 1904 Poor Law enquiry, but also mentions the reduction of the proportion of the MRG to the Highlands, not explicitly as a factor in the establishment of the Dewar enquiry but as one of the issues which raised awareness of the problems of medical provision in the Highlands. In *The Healers* Hamilton attributes the establishment of the Dewar enquiry to the forthcoming National Insurance Act, but also (briefly) raises other issues leading up to it, including the unrest in the Highlands in the later decades of the nineteenth and the need for military recruitment from those areas, the poor supply of doctors and the poor working conditions, which presents a more convincing multi-dimensional perspective, which will be expanded in this chapter. While neither Jenkinson or Dingwall discuss the Dewar Committee, McCrae’s discussion of the enquiry – a factual summary of the published report – ends in an assumption that a scheme contained in the report by Leslie MacKenzie, to

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<sup>8</sup> J.P. Day, *Public Administration in the Highlands and Islands of Scotland*, London, 1918, p.130; Katherine, Duchess of Atholl, *Working Partnership*, London, 1958, pp.66-67; J.D. Comrie, *History of Scottish Medicine, Vol.11*, London, 1932, p.792; T. Ferguson, *Scottish Social Welfare 1864-1914*, Edinburgh, 1958, p.8.

consolidate medical services in the Highlands was implemented, which is a substantial error; the scheme was never implemented.<sup>9</sup>

Knowledge about the background to the Dewar report is clearly limited; both this and the next chapter are intended to redress this gap in the historiography. Issues which are examined and assessed include changing perceptions of the area throughout the previous two centuries and the gradual recognition during the later decades of the nineteenth century of the Highlands and Islands as an area requiring, and increasingly perceived as deserving special attention. Further to the changing perceptions of the Highlands political issues were also relevant. From the 1880s the political environment of Britain, both internally and in relation to Europe, changed which resulted in increased government intervention. That process culminated in 'New Liberalism' and the welfare reforms of the early twentieth century. The impact of the National Insurance Act and the difficulties of implementing it in the Highlands, as a factor in the establishment of the Dewar Commission will be addressed.<sup>10</sup> While the National Insurance Act was clearly a strong catalyst for the establishment of the Dewar Committee, a body of evidence had been built up from the numerous government enquiries which had taken place from the later decades of the nineteenth century. They had raised awareness in parliament and within the medical profession of the conditions of the people and the lack of medical services in the Highlands and Islands. The need to maintain stability in the region following the turmoil of the land wars and the existing heavy burden on the rates within Highland counties were related concerns as was the potential impact of poor medical provision on an area which traditionally supplied large numbers of adult males into the armed forces.

#### **4.1 The Highlands and Islands as a special area**

Part II of the report of the Dewar Enquiry was entitled 'The Highlands and Islands as a Special Problem', demonstrating a mindset which had been developing for over a century. Changes in the perception of the Highlands within central and local government as an area requiring special consideration occurred throughout the

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<sup>9</sup> D. Hamilton, 'The Highlands and Islands Medical Service', in *Improving the Common Weal*, Edinburgh, 1987, pp.484-5 & *The Healers: a history of Medicine in Scotland*, p.246-7; J. Jenkinson, *Scotland's Health*, p.123; H. Dingwall, *A History of Scottish Medicine*, Edinburgh, 2003, p.214.

<sup>10</sup> These issues are frequently raised in the Commons and Lords and by the medical profession in the *BMJ*.

eighteenth century.<sup>11</sup> The early uprisings and the final Jacobite Rebellion of 1745 focused attention on the Highlands as an area clearly and unambiguously requiring special attention. The social, economic and cultural ‘civilisation’ of the Highlands, which included the abolition of traditional clan dress, arms and the destruction of traditional clan chiefs’ powers effectively destroyed much of traditional Highland culture and society, and increased state control throughout the Highlands.<sup>12</sup> ‘The obstacles which traditional Highland society had put in the way of such exploitation were removed’ paving the way for the modernisation of the Highland economy.<sup>13</sup> Simultaneously, the process of physically integrating (and pacifying) the Highlands more closely with the Lowlands had already commenced during the early decades of the eighteenth century with the construction of more than 250 miles of roads, barracks and over 40 stone bridges by General Wade, followed in the early nineteenth century by the construction of nearly 1000 miles of road, over 100 bridges and the construction of the Caledonian Canal between Fort William and Inverness, arising from Thomas Telford’s survey of the Highlands.<sup>14</sup>

Landed estates belonging to Jacobite sympathisers, located from Perthshire to Ross and Cromarty, were annexed as part of that process, and unlike other earlier instances where measures had been taken to control ‘wild areas’ - in the Ulster Plantation and in Fife – it was decided that the proceeds of the estates should benefit those areas of forfeiture. Smith considered this to be the first time the Highlands received separate treatment within the United Kingdom: ‘The act shows unmistakable traces of philanthropy towards, and an embryonic sense of the value of, different regions of the United Kingdom...’. The administrative body, the Board for the Annexed Estates, has also been referred to as the first Highlands and Islands Development Board, which is a reasonable parallel, given that body’s compulsory powers of purchase to facilitate economic development plans, in the region and in its short-lived existence.<sup>15</sup> It was the

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<sup>11</sup> The Report of the Dewar Committee used this term to describe the distinctive nature of conditions in the Highlands, *Dewar Report*, p.6.

<sup>12</sup> Those measures were carried out under the terms of the Act of Proscription, 1746. See also A. MacInnes, *Clanship, Commerce and the House of Stuart, 1603-1788*, Edinburgh, 1996 and ‘Jacobitism in Scotland: episodic cause or national movement’, *Scottish Historical Review*, 86, 2, 2009, p.225-252; M. Pittock, ‘Plaiding the invention of Scotland: tartan and Scotland, 1690-1830’ in Brown, I. (ed.), *From Tartan to Tartanry: Scottish Culture, History and Myth*, Edinburgh, 2010.

<sup>13</sup> Hunter, *Crofting Community*, p.11.

<sup>14</sup> Smith, unpublished PhD thesis, *Development of Roads in the Northern Highlands*, University of Aberdeen, pp.44-56.

<sup>15</sup> A Smith, *Jacobite Estates of the Forty-Five*, Edinburgh, 1982, p.21.

first in a series of bodies which were established to develop the economic potential within the Highlands.<sup>16</sup>

During the Board's existence it attempted, with varying levels of success, to establish planned villages, manufacturing industries, and to improve transportation including roads, bridges and inns, piers, harbours and ferries. Its work also underpinned the importance of the maintenance of accurate recordkeeping, particularly landholding records which could prove and provide proof of title. To secure the preservation of the nation's records, in 1774 it provided the initial funding for the design and construction of a 'proper Repository for Records in Scotland', H.M. Register House in Edinburgh, the first custom designed record repository, designed by the classical architect, Robert Adam.<sup>17</sup>

The initial process of integration was protracted, but persistent, and initiatives in the 1750s, such as the development of small towns such as Callander and Kinloch Rannoch, encouraged agricultural improvement and the development of local trades and manufactures such as milling, spinning, weaving and blacksmithing. Furthermore, young apprentices were sent to the lowlands to develop their skills and in doing so became imbued with the ethos of lowland cultures and norms.

The dissolution of the Board for the Annexed Estates in 1784 reflected, even in those early years, a significant change in perception of the Highlands, both of the principle of forfeiture, and of the previously rebellious families whose estates had been seized. The return of the Annexed Estates to their owners following the Board's dissolution indicated that the threat of future rebellion within the Highlands was perceived to have diminished. The Jacobite failure at Culloden, though an important factor, was not solely responsible for that change of opinion: earlier developments were already under way between the Lowlands and the Highlands. The gradual penetration of Lowland commerce and the English language and the spread of Protestantism into the Highlands had already started to erode the traditional Highland culture. For example, the Scottish Society for Promoting Christian Knowledge (SSPCK) was formed in 1709 to teach 'the true religion and instruction in English as Gaelic was viewed as one

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<sup>16</sup> Other bodies include the Crofters Commission and the Congested Districts Board.

<sup>17</sup> Smith, *Jacobite Estates*, p.21.

of the roots of the “barbarity and ignorance” from which political disloyalty was generated’.

During the eighteenth and first half of the nineteenth centuries most of the teachers in Shetland were from the SSPCK.<sup>18</sup> All of those factors reduced and weakened the grip of many old culture and customs.<sup>19</sup> Some were more enduring than others, such as traditional medicine, practiced by ‘healers’. Customs included ‘distance healing’ ‘sweating cures and the visiting of wells’ and continued well into the twentieth century.<sup>20</sup> The Dewar report and evidence reported many references to the continuation of ‘Primitive Customs and Habits’.<sup>21</sup>

When they have bone disease they use the old remedies. There was a man suffering from keratitis and he was not getting well. It is a difficult disease to cure in an old person. He was not getting on, and I had to go over one very wild day to see him, and when I arrived he was away from home - it was a fearful day—and he had to drive nine miles and walk about another six to an old lady at Licisto. The old lady made up some rhyme and mixed some grasses with water and sand, and sang. He came back and said he was a little better. The seventh son is supposed to be able to cure such diseases. I know of one case of a person who had a carbuncle on the back of his neck and it did not heal, and he got a seventh son to come to his house, and every night for a long time he put cold water on it and a sixpence round his neck.<sup>22</sup>

Maternity care was another area where old practices continued, any improvements encouraged by doctors inhibited by the lack of trained midwives. ‘It is in such a field of ignorant faith that the – skilly woman can practise all her arts at will, and with greatest danger where she is most in demand – and that is, in cases of maternity.’<sup>23</sup> Often local women were preferred to the doctor, they were familiar and their fees were lower. The doctor in Harris replied to the Dewar Committee query, ‘They never send for you unless it turns out to be serious?—The old ‘skilly wife’ is still to the fore.’<sup>24</sup> In North Uist the doctor reported that to end the practice another nurse was

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<sup>18</sup> [http://shetlopedia.com/Teachers\\_of\\_Shetland\\_1771\\_-\\_1852](http://shetlopedia.com/Teachers_of_Shetland_1771_-_1852) (accessed Jan 2011).

<sup>19</sup> Devine, *Scottish Nation*, p.95.

<sup>20</sup> M. Beith, *Healing threads: traditional medicines of the Highlands*, Edinburgh, 2004, p.104.

<sup>21</sup> Part II, Section 5.21 of The *Dewar report* contains examples of ‘Primitive Customs and Habits’, p.9.

<sup>22</sup> *Dewar Evidence*, Q.13,589, p.282.

<sup>23</sup> *Dewar report*, Part II, Section 5.21, p.10.

<sup>24</sup> *Dewar Evidence*, Q.13,772, p.288.

necessary. 'Here we have now two, and they have quite enough to do. Another would be necessary if we are to eliminate the 'skilly' nurse—and the sooner the better.'<sup>25</sup>

Fenyô has documented the dual image of the Highlanders, which existed throughout the eighteenth and early nineteenth centuries, described as both feckless and romantic, '...perceived as a "diseased" and "damaged" part, which had to be removed from the "healthier" body of the nation.'<sup>26</sup> During the seventeenth century the Highlander was a caricatured figure, 'feckless and thievish, while his costume, the belted plaid, was an object of ridicule'. Even during the famine they were perceived as 'habitually "lazy" and "barbarous" ...clearly an "inferior race" to them [the lowlanders]'. The Fifeshire Journal reported in 1847 'The great cause of destitution is...not the failure of the potato crop last year, but...the intense and abominable idleness of the inhabitants'.

Concurrently with the above negativism, the perception was changing and by the 1770s the Highlands, 'formerly looked upon as a nuisance to these islands [were]...valued for their scenic beauty, and their inhabitants as a vital source of supply for the armed forces.'<sup>27</sup> Once it was clear that due to the encroachment of lowland norms, trade and infrastructure, further uprisings were unlikely, the image of the Highlanders altered, albeit over time, from a backward, uncivilised people to a culturally rich and threatened society.<sup>28</sup> (See Appendix 1, Can This Be the Land.)

Three main events encouraged that transition in perception: first, the establishment of the Highland Society in London in 1778, which aimed to preserve 'ancient Highland tradition' within the wider context of the UK. Second, the visit of George IV in 1822 (masterminded by Walter Scott, who had founded the Celtic Society of Edinburgh in 1820) and his appearance in full Highland regalia, 'a stupendously successful publicity stunt', transformed the Highland iconography of tartan and bagpipes into Scotland's national dress. Third, the Royal purchase of Balmoral in 1848, with kilt-

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<sup>25</sup> Dewar Evidence, Q.13,818, p.286.

<sup>26</sup> Krisztina Fenyô, Contempt, Sympathy and Romance, Lowland perceptions of the Highlands and the clearances during the Famine years, 1845-1855, unpublished PhD thesis, University of Glasgow, 1996, pp.1-8.

<sup>27</sup> Smith, unpublished PhD thesis, Development of Roads in the Northern Highlands, p.224.

<sup>28</sup> L. Leneman, ed., *Perspectives in Scottish History*, Aberdeen, 1988, p.108. The construction of the romantic image of the Highlands by Scott has also been criticised as having hindered potential progression, it 'deprive[d] the Highlands...of any progressive identity, for while the region is constructed romantically it is simultaneously consigned the past...belonging to a lost or rapidly fading world'. The exaltation of the tragic glory of the Highlands is illustrated in a contemporary poem, Can this be the land? See Appendix 1. *The Project Gutenberg EBook of The Celtic Magazine, Vol. 1, No. 3, January 1876, by Various. 'Can this be the Land?'*, Wm. Allan, Sunderland, p.87. <http://www.gutenberg.org/files/29969/29969-h/29969-h.htm>, accessed 7 August 2010.



clad ghillie John Brown's public proximity to Queen Victoria, gave a new impulse to clan tartans, as did Highland scenery, Highland cattle and the portraits by Sir Edwin Landseer.<sup>29</sup> Opinions of the Highlands were also influenced by the impact of urbanisation on the Lowlands, 'The Highlands were thought to be a purer Scotland, unsullied by urbanisation'.<sup>30</sup> Paradoxically, as the government sought to unite the Lowlands and Highlands into one cohesive unit following the collapse of the Jacobite rebellion, the developing romanticisation of the Highlands encouraged a Scotland of two parts, the industrial south and the romantic north, containing 'peaceable and loyal' Highlanders'; contributing to an enduring cultural and economic disparity within Scotland. Withers summed up the paradox between the reality and the generation of the myths of the Highlands, 'The Highlands are both real – an area of upland geologically largely distinct from the rest of Scotland – and they are a myth, a set of ideologically laden signs and images.'<sup>31</sup> However, the mythology which developed of a romantic Highlands did not reflect the reality of life for many in many remote areas, where, both before and after the clearances and famine, relentless poverty was the norm for the majority.<sup>32</sup> Furthermore, the traditional ways of life, based on clanship and deep attachment to the land, had been destroyed, leaving a persistent folk memory of loss and betrayal.<sup>33</sup> An article in the *Celtic Magazine* in 1877 which 'had the objective of stripping away the romantic view of life in the Highlands and presenting the realities of the situation' exposed the 'actual misery endured by the great majority of these poor helpless creatures...'<sup>34</sup>

While earlier perceptions of the Highlands were largely imposed from outside the area, Cameron has identified a further change in perception from the 1880s, which was generated largely from within the Highlands. Following an economic downturn in 1881, increasing hardship resulted in greater numbers of 'poverty stricken claimant(s) for philanthropic relief'. In the same year land based protests, including rent strikes,

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<sup>29</sup> Devine, *Scottish Nation*, p. 234; M.G.H. Pittock, *The Invention of Scotland; The Stuart myth and the Scottish Identity, 1638 to the present*, London, 1991, p.102; A. MacLeod, *From an Antique Land: Visual Representations of the Highlands and Islands 1700-1880*, Edinburgh, 2012.

<sup>30</sup> R.J. Finlay, 'National Identity: From British Empire to European Union, in (Eds.), A. Cooke et al, *Modern Scottish History: 1707 to the Present, Vol. 2: The Modernisation of Scotland, 1850 to the Present*, 2003, p.28.

<sup>31</sup> C. Withers, 'The Historical Creation of the Scottish Highlands' in I. Donnachie & C.A. Whatley, *The Manufacture of Scottish History*, Edinburgh, 1992, p.143.

<sup>32</sup> E. Richards, *The Highland Clearances*, 2000, p.312.

<sup>33</sup> L.Gourevidis, Unpublished PhD thesis, 'The Image of the Highland Clearances, c.1880-1990', p.xv;

<sup>34</sup> E. Cameron, *Poverty, Protest and Politics: Perceptions of the Scottish Highlands in the 1880s*, *Mìorun Mòr nan Gall, 'The great ill-will of the Lowlander'?: Lowland perceptions of the Highlands, Medieval and Modern*. University of Glasgow, Glasgow, 2009, p.218-9.

occurred, the biggest impact caused by the 'Battle of Braes'. Thus, the 'perception of the peaceable and loyal Highlander was challenged'.<sup>35</sup> The outcome of the dissent and protests in the Highlands in the 1880s was direct government intervention, which resulted in the establishment of the Napier Commission and the Crofters Holdings Act in 1886.

The significance for this study of the events of the 1880s was the increased profile which was provided to the Highlands. Though the primary issues being considered were land based,<sup>36</sup> which the government attempted to ameliorate by special legislative recognition, a number related to or included the lack of medical services.

Arising from the enquiries the Crofters Commission and the Congested Districts Board were appointed 'for the exercise of special functions in certain defined areas'. Both had troubled passages at their inception which Day attributed to the perceived imposition of central government on the Highlands, with no local involvement; they were '...bodies appointed by, and responsible to, the central authorities, and though their power was definitely restricted to the crofting counties and the congested districts respectively, yet the people of these localities had no direct control over them...'<sup>37</sup> Thus they represented the central authority working in a special district through a special agency'.<sup>38</sup> The Highlands and Islands Medical Service was later to emulate this model and the experience of the Congested Districts Board grants were cited to support 'the principle that the State as a whole should contribute to the necessities of individual localities'. '...just like what we have had by grants under the Congested Districts Board.'<sup>39</sup>

The extended debate in the Lords on the final report of the Congested Districts Board in April 1913 is illuminating in the language used and in the clear recognition that the circumstances leading to the distressed conditions in the Western Isles and other areas of the Highlands and the difficulties of the population to improve their conditions were not, on the whole, of their own making.

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<sup>35</sup> Cameron, *Poverty, Protest and Politics*, p.220-224.

<sup>36</sup> The principle legislative acts relating to the Highlands and Islands during this period were *The Crofters Holding Act, 1886*; the *Congested Districts (Scotland) Act, 1897*; the *Small Landholders (Scotland) Act, 1911* and the *Land Settlement Act, 1919*. The major source which analyses land legislation in this period is E. A. Cameron, *Land for the People: The British Government and the Scottish Highlands, c.1880-1925*, East Linton, 1996.

<sup>37</sup> For a full analysis of the work and impact of these agencies see Cameron, *Land for the People*.

<sup>38</sup> J.P. Day, *Public Administration in the Highlands and Islands of Scotland*, Edinburgh, 1914, p.32.

<sup>39</sup> *Dewar Evidence*, Q.2405, p.71.

...we see now that it is impossible for these people who have been planted on this land to earn a living. They can only exist by the generosity of the State, and by in almost every case receiving Poor-law relief. I do not think that this is an existence which should be continued. It must be bad for their independence and bad for their character generally.<sup>40</sup>

In comparison to earlier periods therefore, the conditions the people found themselves in was not perceived as arising from innate weaknesses of race or intelligence and they were not perceived as being universally of bad character, as would have been the case in earlier years. Although the reaction of the crofters to the distress, in terms of not accepting re-settlement was criticised, and the necessity for migration stressed, they were viewed with a greater level of compassion and understanding and much criticism was focused on the Board. Its approach was perceived by a number of speakers as treating the Highlands as a laboratory, ‘...experiments in regard to this problem of congestion in the Western Isles and Highlands must be tried. There is no royal road to set everything right in a moment; and it is quite possible that that in carrying out these experiments some mistakes may have been made ... a great many of these experiments have been made in the very worst places’.<sup>41</sup> ‘The Marquess of Lansdowne stated that while most were committed to the Board, the work not of one Party but of both Parties’, he conceded that they were ‘entitled to examine with a somewhat critical eye experiments of the kind of those which are now in progress in these Highlands and Islands’ and that they should not view those experiments critically on the basis that they had involved any ‘uneconomic expenditure’. The requirement for external help and the lack of an effective solution in the Crofters Commission and the Congested Districts Board was clearly recognised, ‘...these Boards have been muddling along in these remote regions trying experiments and persisting in those experiments long after it has become evident that they are not in the least likely to succeed’.<sup>42</sup>

The impact of the situation on medical services was also noted by Lord Emmott, ‘The recent and, I must say, rather painful report of the Highlands and Islands Medical Service... points out a good many difficulties in regard to medical services in those districts, and also raises the question of pauper lunatics and other matters’. Lord

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<sup>40</sup> Lord Clinton, *HL Debates*, 23 April 1913, Vol.14, cc256-80.

<sup>41</sup> Lord Emmott, *HL Debates*, 23 April 1913, Vol.14, cc256-80.

<sup>42</sup> The Marquess of Lansdowne, *HL Debates*, 23 April 1913, Vol.14, cc256-80.

Lansdowne commented on the parallels of experience documented by both the Congested Districts report and ‘an extraordinarily interesting document’ - the *Dewar report* - pointing out that no-one; crofter, taxpayer or landowner, benefited from the prevailing conditions in the Highlands.

Despite their limited impact the Congested Districts Board and the Crofters Commission were as important in political terms in drawing public attention to improvements to alleviate the crofters' plight, as they were in the execution of practical improvements. The trust that the Commission engendered from crofters, at a time when branches of the government were viewed with suspicion, has been cited as cementing the principles inherent in the 1886 Act.<sup>43</sup> That goodwill, together with the familiarity of the bureaucratic machinery required by the Congested Districts Board and the Commission, in raising awareness of the conditions in the Highlands and Islands, paved the way for the successful passage of the HIMS. Governmental and societal concern was sustained and encouraged by the rising political and social motivations and aspirations of the Highland population, which were facilitated by improved communications and trade with the industrialised south. The Small Landholders (Scotland) Act of 1911 extended government land purchase powers under the auspices of the Board of Agriculture for Scotland and the Scottish Land Court, but with the onset of the war little was achieved until 1919, when the government passed further legislation.

#### **4.2 Social and economic conditions and the impact of poor medical services**

In addition to land-related legislation the government also commissioned enquiries into various other aspects of social and economic conditions in the Highlands. Reports such as the 1902 enquiry into the condition of the cottar population of the Lews and the Local Government Board's 1906 enquiry into the burden of rates and financial position of the Outer Hebrides emphasized the particular difficulties of remoteness and isolation, while the Poor Law Medical Services Report of 1905 and the Royal

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<sup>43</sup> Cameron, *Land for the People*, pp. 60-61; *Report on Poor Law Medical Services*, 1904, Vol.1, Cd.2008; *Report of the Departmental Committee on the Poor Law Medical Service (Scotland) Minutes of Evidence and Appendices*, 1904, Cmd.2002; Royal Commission on the Poor Laws and Relief of Distress. *Report on Scotland*, Cd.4922, 1909; *Report on Burden of Existing Rates and the General Financial Position of the Outer Hebrides*, Cd.3014, 1906;

Commission on the Poor Law in 1909 reported and increased awareness of the persistent problems in securing medical services in the Highlands.

The Royal Commission on the Poor Laws reported in 1909 that despite the aid provided by the MRG, medical attendance in the Highlands and Islands was 'deplorably insufficient, (affecting)... not only the physical well-being of the paupers, but also that of the whole population'.<sup>44</sup> Moreover, they held that:

the paupers themselves (were) better off in respect to medical attendance than the classes immediately above them. The problem in those parishes (was) to secure a minimum of medical attendance for the inhabitants.<sup>45</sup>

The problems were extensive and complex and many of the same issues as were experienced during the nineteenth century still existed. (See Chapter 3 (3.4)).

Throughout the region difficulties were still experienced in attracting doctors to Highland parishes, with the lack of suitable housing the main issue. Other factors, including salary, the lack of tenure and related instances of bullying, the difficulties of taking holidays and lack of opportunities to keep up with professional developments, all of which were repeatedly cited as preventing posts from being filled. As details of the poor working conditions were widely reported, it was inevitably difficult to fill vacant posts. North Mavea parish in Shetland received only one application for the post of parish medical officer in c1908, when the salary offered was £45 and the northern islands had severe problems recruiting doctors.<sup>46</sup> The low application rates were encouraged by the *British Medical Journal*, which documented fierce criticism against these perceived abuses, which was widely reported in the press. Counter-advertisements were published in the press to warn doctors of the poor conditions. The conditions were long-standing and government awareness of the problem was not sufficient to stimulate action in this area.<sup>47</sup> The Secretary for Scotland, Lord Balfour of Burleigh, was asked to enquire into the Poor Law Medical Service, to improve the condition of the service in the Highlands, but ignored a scheme drawn up by a medical witness to the Local Government Board. The Local Government Board tried to improve the conditions of the service in the Highlands with suggestions on

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<sup>44</sup> R.C. *Poor Laws*, 1909, p.152-3.

<sup>45</sup> R.C. *Poor Laws*, 1909, p.152.

<sup>43</sup> *Dewar Evidence*, Q.7395, p.163.

<sup>47</sup> *Dewar Evidence*, Q2689, p.78.

emoluments and security of tenure but 'both parties (were) equally unsympathetic'.<sup>48</sup> It was unable to force parish councils to improve the conditions of medical officers. When queried on the issue of annual holidays the Board expressed its sympathy and was of the opinion that it would be 'to the advantage of the public service' for parish councils to provide doctors with a holiday, providing a locum during his absence. It also pointed out the problems it had in enforcing councils to comply with their wishes.

...as the Board have often had occasion to point out, their powers in regard to the relation subsisting between parish councils and their medical officers are very limited, being derived solely through the medium of the grant in aid of medical relief to the conditions in connection with the distribution of which parish councils are required to conform in order to participate. ...the rules of the grant [are] stereotyped by the Local Government (Scotland) Act of 1889, so that ...additional legislation would be necessary to give special effect to the views of the medical officers. The Board...are prepared to do the best within their power...[and] will offer no objection to the cost of substitute medical officers being ranked against the Medical Relief Grant in the more remote parishes of the Highlands and Islands of Scotland, provided that the local circumstances are such as are described in the memorial, and provided care be taken that the parish councils shall pay only for the services rendered by the substitute to the paupers and not for the services to the medical officer's private patients.<sup>49</sup>

The provision of men to the armed forces from the Highlands and Islands was indicative of another area of concern, and a contributory factor to the establishment of the Dewar enquiry.<sup>50</sup> Traditionally supplying large numbers of men into the armed forces and concern about the physical condition of potential recruits in that area can be considered a contributing factor supporting the establishment of the Dewar Commission, particularly when the prospect of war with Germany was growing. Following the Boer War military weakness and defeat in battle engendered debate in a number of areas. An underlying theme which caused increasing concern was the implication of the under-performance of a physically deprived population. This factor increased emphasis on the movement for 'national efficiency', focusing on the national debate on the need to ensure supply for the regiments and ongoing security of

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<sup>48</sup> *Dewar Evidence*, Q.2689, p.78.

<sup>49</sup> *BMJ*, August 18, 1900, p.457.

<sup>50</sup> Hamilton also raised this as an issue, but with little detail, in *The Healers*, p.246.

empire.<sup>51</sup> The annual army and naval estimates during the first decade of the twentieth century stressed the need to prevent any lessening of the strength of the armed forces. Debate on the 1905-6 Navy Estimates focused on maintaining the strength and capacity of the Fleet aligning it directly to the need to attain national efficiency. '...if the Admiralty pursued the policy of starving the Royal dockyards that would be fatal to national efficiency'.<sup>52</sup> Similarly, debate on the Army Estimates considering the placement of Scottish troops were met with the hope that 'all such matters would be decided from the point of view of the national army and national efficiency'.<sup>53</sup> Within the national debate there was also an awareness of the need to maintain public order in the still politically sensitive Highland areas. In addition to growing awareness that the country's economy, military standing and security was increasingly vulnerable to international competition and military threat was the added potential threat of internal disorder, for example, in politically sensitive areas such as the Highlands, which contained large numbers of anti-landlord Liberal voters.

Evidence in the Dewar Report emphasised the numbers involved: 'Every man in Lewis is a trained man. They are all Militiamen or Reserve man (sic)'; 'The whole battalion of Seaforth Highlanders (were) Lewis men and a considerable proportion of Camerons and Gordons also.'<sup>54</sup> In 1912 the medical officer of Barvas, Lewis, was of the opinion that almost every able bodied man in his parish, in addition to being crofters, were fishermen and trained Naval Reserve or Militia men.<sup>55</sup>

However, the supply of recruits came from quite geographically distinct areas of the Highlands, principally from the east and west coast of Inverness-shire, Ross, Skye and the Outer Isles, and formed a small proportion of the overall numbers enrolled in the armed forces in Scotland by this period.<sup>56</sup> 26,069 fresh recruits to the Special Reserve were obtained throughout Scotland in 1909.<sup>57</sup> Of this total two Highland divisions, the Highland Light Infantry, 4th Battalion, and the Argyll and Sutherland Highlanders

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<sup>51</sup> G.R. Searle, *The Quest for National Efficiency: A Study in British Politics and Political Thought 1899-1914*, (2<sup>nd</sup> Ed.), London, 1990.

<sup>52</sup> Searle, *The Quest for National Efficiency*, 1990. Concern was raised at the prospect of the Royal dockyards becoming primarily used for repair and not the constructions of new ships. Navy Estimates, 1905-6, *HC Debates*, 13 March 1905, vol.142, cc1231-86.

<sup>53</sup> *Army Estimates*, 1907-8, *HC Debates*, 20 June 1907, vol.176, cc.638-94.

<sup>54</sup> *Dewar Report*, Q.10,926, 11,315, pp.229, 240.

<sup>55</sup> *Dewar Evidence*, Q.12,314, p.258.

<sup>56</sup> *R.C. on the Militia and Volunteers. Minutes of Evidence*, Vol.11, 1904, Cd.2063, p.148.

<sup>57</sup> *Memorandum of the Secretary of State for War relating 1913 to Army estimates for 1909-10*. 1909, Cd.4495.

provided only 1,145 men respectively.<sup>58</sup> Furthermore, queries concerning the numbers enlisted in the Forces concentrated, not on their physical condition, but on their earnings from temporary military employment. The physical condition of men in the Highlands was documented as being satisfactory and in many cases superior to that of urban recruits, and in areas with limited recruitment no special effort was made to rectify this or to encourage recruitment.<sup>59</sup> Interest in the level of recruitment to the Armed Forces in the Highlands can be seen as a recognition of the potential income, and of less importance, as reflecting a general concern on a national level and not one specific to the Highlands. Nevertheless, the Highlands as a source of manpower for the forces was a significant factor in the changing perceptions of the Highlands. In 1893 at the 106<sup>th</sup> anniversary of the Highland Society of London the Highland regiments were lauded, ‘A proud position, indeed, to command a Highland Brigade! “Les brave Ecossais”, said Napoleon, and indeed, every Scottish regiment had a history to be proud of – (cheers) – but which of these Scottish regiments was the best...“Those Highland furies...rushed in upon us with more violence than ever did the sea driven by a tempest”’.<sup>60</sup>

### 4.3 Political factors

The previous factors: the difficulties surrounding the provision of medical care and the impact on military recruitment; the changing perceptions of the Highlands in the public consciousness and the need to maintain stability within the region were important factors in the decision to establish the Dewar Commission. They provided a social, economic and cultural local context within wider political issues. The political climate from the 1880s was dominated by the issues of Irish Home Rule and Irish militancy, Empire and land issues both in Ireland and Scotland, which Sykes has documented as ‘...the growing importance of the politics of the Celtic fringe’.<sup>61</sup> The Marquess of Landsdowne stated, in the context of congestion in the Hebrides, in the Lords,

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<sup>58</sup> *Army Special Reserve. Statement showing Strengths of the Extra Battalions of the Special Reserve of 1 March 1909*, Cd.4497.

<sup>59</sup> *Report of the R.C. on Physical Training (S)*. Vol.1. *Minutes of Evidence and Index*, 1903, Cd.1508, p.195.

<sup>60</sup> Major General Sir Charles McGregor was proposing the health of General Sir Archibald Alison and his service in Egypt. Alison was the General officer commanding British troops in Egypt in 1882. *The Scotsman*, March 24 1884, p.5.

<sup>61</sup> A. Sykes, *The Rise and Fall of British Liberalism*, London, 1997, p.128.



Considering what has already happened in the areas which are dealt with in this report, [the Dewar report] I do trust that His Majesty's Government will be a little careful how they press this policy any further when they are dealing with regions as uncompromising as these West Highland regions. There is, it seems to me, a serious danger in creating...a number of uneconomic holdings...The only result will be that you have an increase in the number of people situated as these inhabitants of Lewis are situated, who are themselves in a very pitiable condition, are a great source of expense to the public, and are in a sense also a danger to the peace and stability of the surrounding community.<sup>62</sup>

Hunter has pointed out that rural unrest was 'widespread' and not confined to the Highlands, but that it did engage politicians including Joseph Chamberlain and Henry George, seeking the rural vote for the Liberals.<sup>63</sup>

Following the mid-Victorian golden age of the Liberal Party, the depression of the 1870s caused a fall in agricultural prices, rents and land values which reduced the economic base on which the landed class – and the Liberal Party's power – rested.<sup>64</sup> Simultaneously, the development of local government; creating county and then parish councils and school boards, 'expanded the sphere of popular democracy' reduced the local influence of the aristocracy at the local level.<sup>65</sup> A considerable diminution in the wealth and power of the aristocratic landed class over the next decades reduced its political power and influence. Harris attributes that to both falling rents and land prices, which reflected both an increased desire to sell land, together with a lack of buyers 'among the owners of new wealth'. He makes the point that land was losing its former status and was not an essential ingredient of social position.<sup>66</sup> Rural unrest in Ireland and the Highlands resulted in government intervention and the passing of the Irish Land Act of 1881 and the Crofters Act in 1886.<sup>67</sup> They guaranteed 'fair rents' and security of tenure and challenged previously inviolate beliefs about the sanctity of property rights but more crucially established a precedent for governmental intervention in the Highlands. Additionally, the extension of suffrage to

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<sup>62</sup> *HL Debates*, 23 April, 1913, vol.14, cc.256-80. Lansdowne was at this time Co-Leader of the Conservative party.

<sup>63</sup> J. Hunter, 'The politics of highland land reform, 1873-1895', *The Scottish Historical Review*, 53, 155, 1974, pp.45-6.

<sup>64</sup> J. Harris, *Public Lives, Public Spirit: A Social History of Britain, 1870-1914*, Oxford, p.102. Wheat prices fell to their lowest level in a century by the 1890s.

<sup>65</sup> Harris, *Public Lives*, p.18.

<sup>66</sup> Harris, *Public Lives*, p.102.

<sup>67</sup> Newby highlights the role of cities, including Glasgow, where Irish and Highlanders formed the Glasgow Land League in support of the Highlanders in A. Newby, *Ireland, Radicalism, and the Scottish Highlands, c.1870-1912*, Edinburgh, 2007.

rural householders in 1884 and the Redistribution Act of 1885, removed county seats and replaced them with single member constituencies. As a result, landed representation in the House of Commons fell significantly from the 1880s. By the election of 1892, only eight per cent of Liberal MPs had a 'substantial landlord background' partly caused by the Home Rule issue, which split the Liberal vote in 1886, while forty four per cent, the largest grouping, comprised businessmen and financiers.<sup>68</sup>

The basic tenets of Liberal policy, free trade and minimal government, gradually came under attack, with calls from business interests for support from the government to secure new markets. Growing utilitarian concerns about social conditions also called into question the foundation of the old Liberal order of unfettered individualism and state non-intervention as the most appropriate way of alleviating the problems of poverty, old age and disease. Attitudes to poverty were evolving and the principles underlying the Poor Law, which focused on poverty as a moral failure, were undermined by the new order which called for active government intervention to improve health and welfare of those in poverty and mitigate the impact of industrialisation and the modern world. The moral imperatives of self-help, free trade and limited government intervention were loosening, paralleled by the increasing secularisation of society. The pace of change was not fast and the certainties of the old order were clung to ferociously by institutions including the Poor Law, the Charity Organisation Society and other charities which believed that assistance for the poor would result in moral degradation. For example, the Webbs regarded destitution as a moral responsibility of the rich and the poor as well as the individual and condemned all forms of poor relief as 'morally harmful'.<sup>69</sup> However, as Digby and Stewart point out, the investigations being carried out within society were providing evidence that the poverty was not caused by moral failure, 'The findings of social investigators suggested that phenomena such as unemployment, poor housing, and the poverty of the old could not simply be explained by individual moral shortcomings.'<sup>70</sup>

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<sup>68</sup> M.J. Winstanley, *Gladstone and the Liberal Party*, Kentucky, 1990, p.57.

<sup>69</sup> A.J. Kidd, 'The State and Moral Progress: The Webbs Case for Social Reform c. 1905 to 1940', *Twentieth Century British History*, 7, 2, 1996, p.195.

<sup>70</sup> A. Digby & J. Stewart, 'Welfare in Context' in *Gender, Health and Welfare*, London, 1996, p.3.

Underlying the changes in governmental actions was the cross-party national efficiency movement.<sup>71</sup> Following the mid-Victorian period of British naval, military and industrial supremacy, the Great Depression resulted in Britain's decline as a great power, military weakness exposed by the Boer War and threatened by the growing industrial, economic and military power of European states such as Germany. There was also a domestic element to national efficiency which sought constitutional and administrative reform. During the latter decades of the nineteenth century an increasing proportion of the population was incorporated 'into the taxpaying classes', which, it has been argued, increased the potential income of central government and its 'power over the allocation of resources in British society...'<sup>72</sup> The civil service machine which expanded and increased central government intervention in local affairs was necessary to assuage the growing financial difficulties faced by local authorities from the 1880s as public health, poor law expenditure rose.

National concerns regarding national efficiency peaked following the Boer War, where the lack of fitness of potential recruits was exposed and the aim of securing a healthy population was viewed as a priority; a healthy working class seen as essential for Britain to maintain its imperial strength and national efficiency.<sup>73</sup> Gaining prominence from the national efficiency movement the *Report of the 1904 Interdepartmental Committee on Physical Degeneration*, which cited widespread problems of general unfitness in the young, caused by poverty which could not be alleviated by local authorities alone led to the establishment of the Royal Commission into the Poor Laws in 1904. According to Harris, it was responsible for widespread debate during the next five years into the nature of central government and society, with a 'dramatic shift in emphasis from local to central government'. There was a precedent for large scale governmental legislation where external pressures had led in the 1880s to land legislation in the Highlands of Scotland and Ireland.<sup>74</sup>

Changes in the established order were intensified by political changes, a diminished landowning elite in parliament and the rise of the Independent Labour Party from 1893, with a growing working class electorate, which the Liberals failed to attract.

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<sup>71</sup> For a very clear description and analysis of 'National Efficiency' see Searle, *The Quest for National Efficiency*, 1899-1914.

<sup>72</sup> Harris, *Private Lives*, p.203.

<sup>73</sup> Hay, *The Origins of the Welfare Reforms*, p.30.

<sup>74</sup> Harris, *Private Lives*, pp.204, 206-7.

From the mid-1890s a group of 'Progressive' Liberals created a new vision of a more interventionist state as a positive force, which formed the basis of the 'New Liberalism' following the landslide victory in 1906. In the period 1906 to 1914 the New Liberalism state interventionist reforms demolished the laissez-faire values prevalent in Victorian liberalism. In those years 'the state, as the embodiment of society's "common will", acquired not only the right, but the obligation, to coerce the individual for his own and society's good.'<sup>75</sup> The social legislation of the first decade of the twentieth century increased governmental responsibility into spheres of life over which it had previously had no or limited authority. The transition from the old order to 'new liberalism' was abetted by the rising dominance of Lloyd George and Churchill as major forces in the new reforms. 'Maverick Liberals... who saw nothing amiss in cooperation with at least a section of the Conservatives...'.<sup>76</sup> Digby & Stewart connect the juxtaposition of a 'declining relative international position and a...possibly "degenerating" race' [following the Boer War] with an increased governmental emphasis on 'ameliorative social policy', which with 'New Liberalism' provided an increased impetus for the welfare reforms of the early twentieth century.<sup>77</sup> The expansion in government activity in the lives of the population during this period, however, was carried out side by side with the poor law; the traditional principles of thrift, saving and self-help sitting beside the new governmental social services. Harris summed it up thus, 'Such ambiguities...accurately reflect the many countervailing social forces that were operating upon law and government in a highly complex and diverse society during a period of widespread structural change.'<sup>78</sup> Those ambiguities were firmly embedded in the Highlands and Islands Medical Service and enforced by the Treasury, which expected and demanded contributions from those benefiting from it.

The most far reaching - and most significant for this study - social legislation enacted was the 1911 National Insurance Act, which insured four-fifths of the working population in the UK against sickness or debilitation. Administered by a range of private industries it further changed the relationship between the state and the individual in the context of welfare provision. Intended to provide medical care for

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<sup>75</sup> Sykes, *British Liberalism*, p.17.

<sup>76</sup> Sykes, *British Liberalism*, p.271.

<sup>77</sup> Digby & Stewart, 'Welfare in Context' in *Gender, Health and Welfare*, p.4.

<sup>78</sup> Harris, *Private Lives, Public Spirit*, pp.218-9.

the employed, on payment of a regular premium, the Act required compulsory contributions of 4d from employees and 3d from employers in return for benefits, to which the State contributed 2d. It also provided treatment for tuberculosis. It was the first piece of legislation which applied insurance principles inclusively, without the selection factor which typified commercial schemes. However, as the contributory element was only available to those in full-time employment and as it discriminated against those who were unable to build up sufficient contributions, were chronically sick or only working on a casual basis, it maintained the principles of self-help among those who were not in financial distress. Put more strongly, 'the policy of insurance was a bold extension of the circle of the more privileged, intended to give certain deserving categories protection from dependence on the Poor law'.<sup>79</sup> The Act met with significant opposition from friendly societies, which lobbied from 1908 to ensure '...that they would suffer no state intervention in their traditional business'.<sup>80</sup> The medical profession also objected vociferously to the constraints of the act and lobbied hard for a panel system, in which the insured could select a doctor.<sup>81</sup> Those early disputes were of little relevance to the Highlands where successful friendly societies were weak and the insured represented a small proportion of the population. For example, Shetland, with a population of 27,790 in 1913, had 4,962 (17.9%) insured persons. 13 doctors, four of whom were based in Lerwick, were responsible for scattered insular communities. In Yell and Fetlar, where only 10 per cent of the 2,627 population were insured, 50 per cent of those were three miles or more, or across water, from Dr Taylor, the sole doctor within 30,977 acres.<sup>82</sup> The few medical clubs in the Highlands which were successful were in areas with reasonable economic conditions or where the estate both controlled and contributed to the club.<sup>83</sup> A major impediment was the small number of members and the inability to afford the contributions by many on low and sporadic incomes.<sup>84</sup> Friendly societies were sporadically located throughout the Highlands, and in some areas, such as Lerwick, there were none.<sup>85</sup>

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<sup>79</sup> Hennock, quoted in Finlayson, *Citizen, State and Social Welfare*, pp.184-5.

<sup>80</sup> P. Thane, *The Foundations of the Welfare State*, London, 1982, p.85.

<sup>81</sup> G. Finlayson, *Citizen, State and Social Welfare*, Oxford, 1994, pp.190-191.

<sup>82</sup> Synopsis of replies to Board's Circular letter of 1 December 1913, HH65/2, 1913.

<sup>83</sup> *Dewar Report*, Section E, 3, 148, p.37.

<sup>84</sup> *Dewar Evidence*, Q.21,760-2, p.148.

<sup>85</sup> *Dewar Evidence*, Q.6545, p.148.

The potential impact of the National Insurance Act in the Highlands was therefore limited. It did nevertheless represent a significant increase in state control over the individual. Previous legislation was more limited, much of it was permissive and amended the responsibilities or privileges of working men. For example, the Workmen's Compensation Acts of 1897, and 1906, merely imposed a duty of legal responsibility on employers. With the introduction of the Old Age Pensions Act in 1908, persons over the age of 70 became eligible for an Old Age Pension, granted without the requirement of contributions but subject to a means test. Other areas of reform included old age pensions, free school meals, enacted in 1906, but not compulsory till 1914, and school medical inspections and various other measures to protect young people, which were enacted through the 1908 Children's Act, cumulatively known as the Children's Charter.

The 1911 National Insurance Act, therefore, marked a significant change in the means of financing welfare. Voluntary benefits were secured from selected friendly societies, known as 'Approved Societies', and a discrete management infrastructure was developed and resources provided to administer the state scheme; the functions authorised and expenses met by the government. The Act was far reaching in other ways also. During its passage through Parliament Scottish Members of Parliament regularly lobbied the government on various aspects of Highland life, and increasingly on the ability to enact the National Insurance Act there. For example, in 1911 the member for Ross and Cromarty, Sir James Macpherson, queried the government as to the necessity of providing a grant-in-aid to the local Insurance Commission to 'secure effective enjoyment of all the benefits of the scheme for the insured persons and fair mileage fees for doctors.'<sup>86</sup> Mr Cathcart Wason, MP for Orkney and Shetland,

While we...recognise the enormous benefits which will accrue to the old country from the operation of this Bill, we are fully alive to the fact that it will not meet the very special circumstances of their [the Highlands and Islands of Scotland] case... The difficulties arise from the physical circumstances of the country and the manner in which the people live... It is no reason because they live on an island far distant from the mainland they

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<sup>86</sup> *The Lancet*, 12 December 1911, p.1670.

should be denied one of the greatest triumphs of modern civilisation – that is, medical attendance.<sup>87</sup>

Another clause, contained in Part One of the Act, stipulated that ‘contributions to insurance must only be paid for a minimum of one week – thus potentially penalising employers who hired workers by the day or by the hour’.<sup>88</sup> The main focus of discussions on this clause was the issue of casual labour in the docks, but in the Highlands casual labour was common. It was prevalent in agriculture, seasonal migration in the herring fishing, the deer estates and other aspects of the developing tourist industry in the Highlands. The Secretary to the Treasury was also questioned as to whether the local Health Commission in Scotland, to be appointed under the National Insurance Bill, would have the power to award additional remuneration to medical practitioners in sparsely populated districts, on the basis of, for example, mileage.<sup>89</sup> Local Insurance Commissioners could, within the resources at their disposal, make such arrangements with medical men as they thought fit. However, attempts by the Board of Supervision between 1845 and 1894 to provide medical relief to paupers had revealed the difficulties inherent in the Highlands of providing medical services for even a small minority of the population. This has been suggested, as detailed earlier, to varying degrees, as a prime motive for the establishment of the Dewar Enquiry and clearly it was a key catalyst in its establishment.<sup>90</sup> However, although the remit was national insurance, the enquiry was broader in focus. The Marquis of Tullibardine requested clarification on that point in Parliament on a number of occasions. In October 1912, for example, following a question on that point to the Secretary to the Treasury, put by Cathcart Wason, MP for Orkney and Shetland. The response from Masterman was that ‘...the reference has been narrowed to what is required under the National Insurance Act but the Committee are still investigating the wider subject.’<sup>91</sup> Later, in January 1913, Masterman commented ‘This Report goes much further than the question of these doctors [on the panels]. It is a very large subject...’<sup>92</sup> Lloyd George acknowledged that ‘The Highlands are a very

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<sup>87</sup> OIA, CO6/11/13, Copy of statement by Mr Cathcart Wason to House of Commons Official Report expressing concern at enactment of National Insurance Bill in Highlands and Islands of Scotland, 13 November, 1911.

<sup>88</sup> Harris, J. *William Beveridge, A Biography*, Oxford, 1977, pp.189-90.

<sup>89</sup> *The Lancet*, 12 December 1911, p.1671.

<sup>90</sup> D. Hamilton, ‘The Highlands and Islands Medical Service’, in *Improving the Common Weal*; M. McCrae, *The National Health Service in Scotland: Origins and Ideals, 1900-1950*, p.1.

<sup>91</sup> *HC Debates*, 28 October 1912, Vol. 43, c.44. The Marquis repeated the question on 21 November 1912 and 21 January 1913.

<sup>92</sup> *HC Debates*, 21 January 1913, vol.47, cc.204-5; 4 February 1913, vol. 47, cc.1991-2.

special case.’ and announced a special grant of £10,000 for the Highlands, in the interim period, ‘...until we can consider a more permanent scheme for extending medical benefits in the Highlands.’ In other parts of the country the insured persons represented one in three of the population, in the Highlands it was one in ten or twelve, a much smaller number of insured individuals, which doctors would have great difficulty in attending. The grant, included in the Supplementary Estimates, was to provide for mileage expenses for doctors ‘for the services of insured persons’. Lloyd George acknowledged the difficulties of travel, ‘They have often to travel fifty miles across very stormy and rough seas in all weathers, and go to the islands where there are neither doctors or nurses, and the poor women are often left without any sort of medical or trained aid in very trying conditions of sickness’.<sup>93</sup> Clearly the Dewar report had made an impact at the highest level.

That impact was not solely due to either the National Insurance Act or the Dewar enquiry. Previous enquiries carried out during the nineteenth century were of great importance in raising widespread awareness of conditions in the Highlands and Islands and the cumulative knowledge gained from those earlier enquiries, many of which emphasised the lack of medical provision, should not be understated. The range of legislation generated during ‘New Liberalism’ aimed to ameliorate the economic and social conditions of specific groups in society by government intervention and assistance, but in all cases expecting a degree of self-help. The National Insurance Act followed that pattern. However, in requiring medical assistance to be provided to the insured in Highlands, which was impossible due to the difficulties associated with the provision of medical services in that region, it effectively prevented the status quo – an over-reliance on the Poor Law medical service for the general population in the Highlands – from continuing in the long term.

It was within this changing political, economic and social context that the Dewar Commission was appointed in July, 1912 to gather evidence on the adequacy of the provision of medical services, the condition of the people and the ability of both the population and local bodies to contribute to the costs of those services.

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<sup>93</sup> *HC Debates*, 7 February 1913. Speech by Lloyd George on National Health Insurance (Special grants, Class VIII.)



## CHAPTER FIVE

### THE DEWAR ENQUIRY AND REPORT

The previous chapter brought together the factors and influences that led to the establishment of the Dewar committee in 1912. The ensuing report resulted in one of the last, and lesser known, Liberal reforms, the creation of the Highlands and Islands Medical Service (HIMS) in 1913, which for the first time would provide medical services to the non-registered poor, on payment of a small fee.<sup>1</sup> Yet, contemporary and modern writings have been largely minimal in extent and, with a few exceptions, have tended to view both the Dewar Enquiry and the HIMS as having provided a constant progression in improvements to medical services, leading directly to the establishment of the National Health Service.<sup>2</sup> None provide a detailed balanced assessment of the enquiry and report. References to the report itself are broadly confined to brief references to the enquiry with summarised findings which have relied almost solely on the report itself, with little contextual information on the reasons for the establishment of the enquiry, its methodology or findings. Comrie, for example, in the first history of Scottish medicine, merely acknowledged the report as having been established a result of the National Insurance Act and having facilitated the HIMS.<sup>3</sup> A further problem is that the conditions found in the Highlands were not to be found, to the same degree, elsewhere in the UK and there is a resultant lack of comparative studies. The uniqueness of the Highland counties was affirmed during the passage of the Bill through Parliament. The only dissent was from other rural areas in the UK, raising objections to the geographical areas chosen to be in the new service. The main area of contention was the inclusion of Highland Perthshire. The difficulties faced by other rural areas were championed by their Members of

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<sup>1</sup> The Highlands and Islands (Medical Service) Grant Act received Royal Assent on 15 August 1913. The Mental Deficiency Act also received Royal Assent that day. *Hansard*, 15 August 1913, Commons sitting; Harris, *Private Lives*, p.208. Harris does not acknowledge the HIMS Act as a social welfare reform. A group formed to celebrate the Centenary of the Dewar Enquiry in 2012 have been successful in raising the profile of the work of the enquiry and in mapping it to contemporary issues of rural practice in the Highlands. Further information is available at [www.ruralgp.com/wp/dewar2012/](http://www.ruralgp.com/wp/dewar2012/).

<sup>2</sup> J.P. Day, *Public Administration in the Highlands and Islands of Scotland*, London, 1918, p.130; Katherine, Duchess of Atholl, *Working Partnership*, London, 1958, pp.66-67; J.D. Comrie, *History of Scottish Medicine*, Vol.11, London, 1932, p.792; T. Ferguson, *Scottish Social Welfare 1864-1914*, Edinburgh, 1958, p.8. The exceptions to a whiggish interpretation of the Dewar Enquiry are D. Hamilton, 'The Highlands and Islands Medical Service' in *Improving the Common Weal*, Edinburgh, 1987, pp.484-5 & *The Healers: A History of Medicine in Scotland*, p.246-7; J. Jenkinson, *Scotland's Health*, p.123; H. Dingwall, *A History of Scottish Medicine*, Edinburgh, 2003, p.214.

<sup>3</sup> J.D. Comrie, *History of Scottish Medicine*, London, 1932, p.792. That view was echoed by Ferguson 20 years later. T. Ferguson, *Scottish Social Welfare 1864-1914*, Edinburgh & London, 1958, pp.462-3. See also Chapter 4 for a discussion of the National Insurance Act.

Parliament but the consensus was that no other geographical regions suffered from the same degree of remoteness as the five counties and Highland Perthshire, which was successfully defended by the Duke of Atholl. The most equivalent conditions are found in Canada, the United States, Scandinavia and Australasia, where extreme remoteness and climate presented extreme obstacles to the provision of medical services. This will be addressed in the next chapter. More recently, valuable work on the public policy of the Highlands by Cameron and Levitt, together with the administrative framework of the Scottish Civil Service (and prominent individuals in that) within which the Dewar Enquiry was placed, has provided a contextual framework for its background and establishment.<sup>4</sup>

This chapter, therefore, provides the first in-depth consideration and assessment of the workings, the relationship with the Treasury and the Scottish Office, and the conclusions of the enquiry. The bureaucratic infrastructure and methodology employed by the Committee, the area and scope of the investigation, the itinerary and witnesses and the structure within which the enquiry was undertaken, will be examined. Those, mainly administrative, issues provide a background and context for the report and evidence and also illuminate some of the difficulties experienced by the Committee in their relationship with the Treasury, primarily the lack of awareness of the impact of working in the remote areas of the Highlands under examination, the geographical difficulties, for example, and the difficulties that were experienced in administering the enquiry. The reasons why additional costs were required in administering the enquiry and travelling in the Highlands were not always appreciated by those in London.<sup>5</sup> That lack of awareness was also experienced by the subsequent medical service which was established following the publication of the report.

The thoroughness of the investigation provided a unique detailed account of life in the Highlands and the state of the unreformed Highland medical services in 1912. From the evidence the Committee were able to establish the main issues, problems and impediments to the provision of effective medical services in the Highlands. Their

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<sup>4</sup> E. Cameron, *Land for the People: The British Government and the Scottish Highlands, c.1880-1925*, East Linton, 1996; Cameron, E., 'Poverty, Protest and Politics: Perceptions of the Scottish Highlands in the 1880s' in D. Broun and M. Macgregor (eds.), *Mìorun Mor nan Gall, The Great Ill-Will of the Lowlander: Lowland Perceptions of the Scottish Highlands*, Glasgow, 2007, published on-line at <http://www.arts.gla.ac.uk/scottishstudies/ebooks/miorunmor.htm>; I. Levitt, *Poverty & Welfare in Scotland, 1890-1948*, Edinburgh, 1988 and *The Scottish Office: Depression and reconstruction 1919-1959*, Edinburgh 1992.

<sup>5</sup> The Treasury Cabinet papers reveal a significant lack of understanding of conditions in the Highlands.

recommendations, designed to reduce the factors causing those problems, will be assessed to permit an analysis and evaluation of the enquiry to determine whether it was innovative; how it sat with other concerns of the time and how important it was both locally to the Highlands and nationally. Any weaknesses in, or omissions from, the Dewar Enquiry will also be addressed.

## **5.1 The infrastructure and methodology of the Dewar Enquiry**

### **I. The Dewar Committee (See Plate 3, The Dewar Committee)**

The Chancellor of the Exchequer, Lloyd George, issued a Minute of Appointment on 11 July 1912 and the Committee was selected, consisting of the Chairman, Sir John Dewar (See Plate 4, Sir John Dewar) eight committee members and a Secretary. The committee comprised three prominent medical experts who provided specialised knowledge on aspects of social welfare and practical experience of working in the Highlands: Dr W. Leslie MacKenzie, medical member for the Local Government Board for Scotland; Dr. John Christie McVail, Deputy Chairman of the National Health Insurance Commission for Scotland and Dr. Alex Cameron Miller, a general practitioner in Argyll. Both Mackenzie and McVail were highly experienced doctors who had been general practitioners and medical officers of health, and in 1912 held major positions in Scottish health administration. MacKenzie was the medical member for the Local Government Board for Scotland and McVail was the Deputy Chairman of the National Health Insurance Commission for Scotland. The aristocracy was represented by the Marchioness of Tullibardine, the only woman on the committee, but with a fiercely strong character she was by no means the token woman. The others were the Factor of the Lews, Charles Orrock, the Conveners of the Counties of Shetland - James Cullen Grierson - and Sutherland - Andrew Lindsay - and the Senior Inspector for Schools in Scotland, John L. Robertson. The Secretary was Murdoch Beaton, a native of the Highlands and an Inspector under the National Health Insurance Commission. (See Plate 5, Murdoch Beaton) Together they provided an impressive body of professional knowledge and expertise, with significant personal experience of economic and social conditions in the areas examined. (See biographies of the Committee members at Appendix 2.)

## II. Remit, Methodology and Administration

The Committee's remit did not specify the exact area to be examined or its methodology and the members interpreted their remit widely. Following discussion they agreed to take evidence from the counties of Argyll, Caithness, Inverness, Ross and Cromarty, Sutherland, Orkney and Shetland, and from the Highland District of Perthshire defined as the districts of Aberfeldy, Aberfoyle, Blairgowrie, Comrie, Killin, Kinlochranoch and Pitlochry). This, they believed, covered the area:

in which isolation, topographical and climatic difficulties, and straitened financial circumstances [were] found most generally in combination, and, therefore, the area in which the question of adequate medical provision [was] most pressing.<sup>6</sup>

The enquiry sought information on all groups of Highland society, but in particular on the class which was ineligible to participate in the National Insurance Scheme, but not poor enough to be entitled to poor relief. This was not always widely recognised and the Dewar Enquiry constantly came up against the belief that the enquiry had been set up only to ensure the efficient execution of the Insurance Act.

The Chairman's reply to one such suggestion belied that view:

You have formed the mistaken idea that we are here in the interests of the Insurance Act. We are not here at all for that; we are here to improve the general medical conditions of the Highlands and Islands.<sup>7</sup>

And on another occasion, 'The object of our visit is to see how we can make the medical service better in the Highlands and Islands.'<sup>8</sup>

In the most timeous methods possible, the Committee amassed as much information as they could in a number of ways. The initial stage in the enquiry took the form of two sets of query schedules with a covering letter, which was issued to doctors and other individuals considered able to provide relevant information. The schedules requested comprehensive information on where doctors worked, what their income was, what experience they had, their working and travelling conditions, including holidays and holiday cover, their housing, other public or private appointments held, the numbers of paupers treated and any local club arrangements. Details on the turnover of doctors in their area was also included. Other questions related to the

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<sup>6</sup> *Dewar Report*, Cd.6559, 1912, p.5.

<sup>7</sup> *Dewar Evidence*, Q.6828, p.153.

<sup>8</sup> *Dewar Evidence*, Q.6988, p.156. See Chapter 4 for more information on this issue.

condition of the people and their ability to pay fees, surgical and maternity issues, levels of uncertified deaths and tuberculosis and the supply of nurses and hospitals. Their opinions and suggestions on the adequacy and future of medical services were also sought. It is clear from the breadth of the questions that the Committee considered that the enquiry was wider than simply the requirements of the National Insurance Act.

The response rate was high, indicating a significant level of interest in the enquiry - and thus justifying its establishment. 260 Schedules were issued, 102 to doctors, and 158 to other persons. Of those, 87 were completed and returned by doctors (85%), and 144 by other persons (91%). In addition to the schedules, the Committee consulted various published papers and reports containing relevant information, in particular the Report by the Poor Law Medical Relief Departmental Committee of the Local Government Board (1904) and the Report of the Royal Commission on the Poor Laws and Relief of Distress (1909). The published Reports of the County Medical Officers of Health, including the Reports on School Medical Inspection, and Returns and Reports issued by the Registrar-General and the Local Government Board, were also found to contain useful information.

The Committee then moved to interview appropriate individuals, both in the administrative centres and during visits to the area under remit, not only to take oral evidence, but to see at first hand the difficulties involved in the provision of medical service in remote areas. The timetable exerted considerable administrative pressure and both Beaton and Dewar were required to fight for additional resources to pay the shorthand writers who accompanied the Committee to the interview locations.<sup>9</sup> Eventually two shorthand writers were employed, one remaining in the Highlands and one returning to Edinburgh to have the notes typewritten as quickly as possible and 'placed in the printers hands with the least possible delay'. This strategy was clearly the key to the speedy production of the report and the evidence. However, as Beaton

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<sup>9</sup> TNA, Minute 16729/12, Payment of attendance fees to shorthand writers travelling with the Highlands and Islands Medical Services Committee, Treasury 18098, 1913. A submission to the Treasury by Beaton for reimbursement of the shorthand-writers fees was initially refused as it was considered they should only have been paid only for days they actually recorded evidence at a fee of £1 1s per day. The owner of the company which carried out the work, Hodge & Co, Inverness, in a letter to Beaton on 30 June 1913, stated that, in his experience, when a shorthand-writer was required outside of Glasgow or Edinburgh, that a fee of £2 2s was allowed by the Treasury for each day his members of staff had been absent, and that such a sum had been paid for work carried out during an enquiry in Haddington and during travel in the Highlands with the Churches Commission. There was therefore clearly a precedence for the additional payments to be made, in recognition of the conditions, distances travelled and need to travel to island locations.

had not queried the original letter of 20 August 1912, containing the direction on fees and a monthly allowance of £5, the intervention of the Treasury to recover the overpayments from Hodge & Co seemed likely till Dewar himself was forced to intervene. In a letter to the Treasury he forcefully and successfully set out the need for the attendance of the shorthand writers. ‘It was absolutely necessary that we should have Mr Hodge in constant attendance with us, as it was quite impossible to get a shorthand writer in the wilds of the Hebrides and the Orkney and Shetland Islands. The circumstances were very exceptional, and I certainly think that the Treasury ought to recognise those exceptional conditions’.<sup>10</sup> The difficulty in making the Treasury aware of the logistical circumstances of working in the Highlands was an early indicator of an attitude that would continue during the enquiry and later. The shorthand writers were allowed 12/6d a night when absent from home and were required to travel third class on railways ‘as a set off to this concession’.<sup>11</sup> A similar justification was required to allow the witnesses travel costs to be reimbursed. The Treasury required some persuasion that the means of attending the enquiry might vary and after some correspondence agreed the following expense allowances:

**Table 5.1 Mileage for travel costs, 1912**

Motor cars with accommodation for more than three persons	6d. a mile
Smaller Motor cars	4d. a mile
Mechanically propelled boats	6d. a mile
Motor Bicycles	3d. a mile
Pair of horses	6d. a mile
One horse	4d. a mile

**Source: Treasury file 17600, Letter to Beaton, 21 August 1912.**

No rate was fixed for the use of a private sailing or rowing boat but rates to a maximum of 5s a day was considered acceptable.<sup>12</sup> Over a period of 29 days, from 15 August to 29 November 1912 interviews were carried out.

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<sup>10</sup> Treasury 18098, Letter from John Dewar to F. Phillips, Treasury, 26 July 1913.

<sup>11</sup> Treasury 16729, Letter to M Beaton, 20 August 1912.

<sup>12</sup> Treasury 17600, Letter to Beaton, 21 August 1912.

**Table 5.2 Number of days, date and location of the meetings carried out by the Dewar Committee, 15 August – 1 November 1912**

<b>Days</b>	<b>Date</b>	<b>Location</b>
1-2	15-16 August	Local Government Board Offices, Edinburgh
3-5	19-21 August	Town Council Chambers, Inverness
6	23 August	Town Chambers, Thurso
7	26 August	Town Chambers, Kirkwall
8	27 August	Nurse Mackenzie's House, Fair Isle
9	28 August	Town Chambers, Lerwick
10	7 October	The Hotel, Bettyhill
11-12	8-9 October	The Reading Room, Lairg
13	10 October	The Hotel, Richonich
14	11 October	The Town Council Chambers, Stornoway
15	12 October	The Hotel, Garrynahine
16	14 October	The Town Council Chambers, Stornoway
17	15 October	The Hotel, Tarbert
18	16 October	Sheriff Court, Lochmaddy
19	17 October	The Hotel, Dunvegan
20	18 October	Sheriff Court House, Portree
21	19 October	The Station Hotel, Kyle of Lochalsh
22	22 October	County Buildings, Perth
23-26	28-31 October	Town Council Chambers, Oban (Witnesses from South Uist and Barra were examined in Oban)
27-29	1 November	North British Station Hotel, Glasgow

**Source: Compiled from Minutes of Evidence, Volume 11, Committee on Medical Service in the Highlands and Islands of Scotland (Dewar Evidence) Cd.6920, 1913.**

Meetings were held in Edinburgh and Glasgow to collect evidence from representatives of major central authorities, who held responsibilities related to the Highlands and Islands. The meeting in Glasgow also included an account on the Dispensary system of medical provision in Ireland from a medical practitioner and from Dr. Coey Bigger of the Local Government Board, Ireland. Evidence was also collected in a number of locations throughout the Highlands and Islands. (See Plates 6 & 7, The Dewar Committee en route to the Western Isles and visiting various locations during October, with signatures of the Committee.)

176 witnesses from a wide range of social and professional backgrounds were interviewed. Nine were aristocrats, including several landowners, such as the Mackintosh of Mackintosh, and eleven held senior positions of responsibility, including the Registrar-General, J. Patten MacDougall,<sup>13</sup> the Statistical Officer of

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<sup>13</sup> Patten MacDougall was from a landed family in Argyll and sat on the Royal Commission on the Poor Laws and Relief of Distress in 1905-9. He was also involved in the Queen Victoria Jubilee Nursing Institute, therefore had a good background knowledge of the issues. More information is available at: [www.gla.ac.uk/departments/scottishwayofbirthanddeath/leadingactors/registrarsgeneral/](http://www.gla.ac.uk/departments/scottishwayofbirthanddeath/leadingactors/registrarsgeneral/), accessed 4/7/10.

Register House, the Secretary of the Local Government Board, the Secretary of the National Health Commission and the Secretary of the Northern Lighthouses Commission. Representatives from the Victoria Jubilee Nursing Association and the General Medical Council were also interviewed. 43 non-medical representatives, holding official positions such as schoolmasters, postmasters, etc., gave evidence, and 18 clergymen and 15 small farmers and crofters, some of whom had previously given evidence to other government enquiries. Most of the medical evidence came from the 78 doctors and two nurses who were interviewed. (See Appendix 4, Circular letter, Sent by Board to localities, 15 January 1914.)

Given the prominence accorded to nursing in the evidence to the enquiry the small number of nurses who were able to contribute to it can be regarded as a significant weakness. It most likely reflected the small number of trained nurses in the Highlands and their lower position in the medical hierarchy, in relation to the medical practitioners. Another potential weakness in the enquiry was the lack of translators. Two members of the Committee were Gaelic speakers, Orrock and Miller but no Gaelic speaking witnesses were interviewed and no translator employed, despite 150,000 Gaelic speakers residing in the counties under examination. That omission may have been to prevent other members of the Committee from being excluded from the discussions, which a translator could have rectified. In 1911 9,829 persons (5.4%) were recorded in the Census as being Gaelic only speakers. The lack of a translator represented an omission and in effect prevented the inclusion of any potential witness who spoke only Gaelic. Although that was a relatively small proportion of the total Gaelic speakers, the majority of the Gaelic only speakers were resident in the Highland counties, where the proportion would have been higher.<sup>14</sup>

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<sup>14</sup> *Census report*, 1911.



**Table 5.3 Native Gaelic speakers in Highland counties, 1881 and 1911**

Native Gaelic speakers in Highland counties	1881		1911	
	Number	% of total	Number	% decline from 1881
Inverness	64,041	31.7	48,780	23.8
Ross and Cromarty	56,086	27.8	46,926	16.3
Argyll	46,503	23	31,695	31.8
Sutherland	17,600	8.7	11,839	32.7
H & W Districts, Perthshire	8,702	4.3	6,636	23.7
Caithness	3,422	1.7	1,685	50.8
Total	202,059		150,571	25.5

**Source: Gaelic speakers by area of incidence 1881-2001: numbers and proportions in areas of different intensity, K. Mackinnon: SGRUD Research. [www.arts.ed.ac.uk/celtic/.../Gaelic\\_area\\_incidence\\_1881\\_2001.ppt](http://www.arts.ed.ac.uk/celtic/.../Gaelic_area_incidence_1881_2001.ppt).**

The interviews were very speedily typed and analysed and the report was published on Christmas Eve 1912, five months after the Committee was established. The Minutes of Evidence were published seven months later in 1913, containing an impressive 23,558 questions and responses and a 159 page index.<sup>15</sup> The speed at which this was executed, and with which the grant to the Highlands was passed through Parliament, suggests a lack of opposition to the enactment of the legislation within parliament and that was the case, broadly speaking.<sup>16</sup> The main debate focused on the areas to be included in the medical scheme but there was no discernible opposition to the Bill *per se*. Masterman, Secretary to the Treasury, when questioned in the Commons by the Marquess of Tullibardine, confirmed that '[it] is, I believe, non-controversial as between the two parties in the house.'<sup>17</sup> The ease at which the enquiry was met and the Bill enacted illustrates the importance of the activity during the preceding decades, which had made it clear that the Report's findings reflected the reality of circumstances in the Highlands and Islands.

## **5.2 The findings of the Committee: the state of medical services in 1912**

Volume I, the Report to the Lords Commissioners of the Treasury, was published on 24 December 1912. The Report was backed up with Volume II, the detailed Minutes

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<sup>15</sup> *Dewar Report*, pp.2-3.

<sup>16</sup> Much of the Hansard debate in the lead up to the publication of the Report centred round requests for the publication date. It was eagerly awaited.

<sup>17</sup> *HC Debates*, 7 July 1913, Vol.55, cc22-3.

of Evidence, published six months later. The Report's structure logically presented the state of medical services and their social and economic context over 42 pages, together with appendices. The Report defined its scope and methodology, set out the issues which defined the Highlands and Islands as a special problem, looked at a range of conditions affecting the adequacy of medical service and then set out the main factors which provided evidence that medical attendance was inadequate. That was followed by sections on the provision of nurses, hospitals and medicines and appliances. The existing medical provision, comprising those services offered by public health, school, insurance, the Poor Law, general practice and specialised services were then recounted and the report ends with the Committee's general recommendations to the Treasury. Five appendices contain: a suggested scheme for the administrative consolidation of medical services in the Highlands and Islands by Leslie Mackenzie; a memo on cottage hospitals proposed to be built (at the end of the Appendices are plans of the two designs of cottage hospitals outlined in the appendix); a list of general hospitals; the questionnaires sent to medical and non-medical witnesses to the enquiry and a list of witnesses.

Parts I and II of the Report explained its remit, scope and methodology and set out the general factors believed to be causing in the Highlands and Islands to be considered a special problem requiring 'exceptional treatment'. They included the precedence of *special legislation recognition*, laws having already been enacted in the areas of land and education in the Highlands; the *difficulties of travel* affecting the ability of medical practitioners to reach their patients; the *circumstances of the people* rendering them unable to pay doctors' fees; *insanitary dwellings* leading to disease and preventing the effectiveness of medical treatment; *Primitive customs and habits* which prolonged the use of traditional cures at the expense of professional medical treatment; *inferior diet* both from inadequate availability of nutritious wholesome food and the increasing consumption of tea and white bread in place of milk and porridge;<sup>18</sup> *Rural depopulation* was deemed to have caused the loss of the healthiest members of Highland society, placing a greater burden on available medical services. Emigration thus left behind 'a larger proportion of weak and unfit, who at all times

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<sup>18</sup> This point was also made by the Duchess of Atholl in *Working Partnerships*, where she recalled the evidence given by a doctor in Barra. p.71.

and everywhere claim the greater share of medical attention.’<sup>19</sup> In addition to emigration, depopulation was also considered to have been promoted by the difficulties of being some distance from a doctor or nurse and the lack of medical treatment.

The increasing *burden of local rates* was viewed as a major factor preventing parishes improving medical provision. For example, in Uig parish the rates rose from 10s 1<sup>1</sup>/<sub>5</sub>d to 23s 3<sup>3</sup>/<sub>4</sub>d in 1912, which was echoed in other parishes of the Western Isles and to a lesser extent, other western seaboard parishes. The cost of retaining a doctor, therefore, represented ‘a heavy charge on an otherwise overburdened rate’.<sup>20</sup> The declining proportion of MRG income placed a further strain on parish finances, with an average of 4s 3d per £ paid, in contrast to 10s 9d ten years previously. In the parish of Portree the MRG which had twenty five years previously covered half the expenditure of medical relief, only covered one fifth by 1912.<sup>21</sup> In that year only £3,000 of the total available sum of £13,000 was paid to Highland counties. From 1885 the conditions of the grant distribution had changed and half the cost of trained sick nursing in poorhouses was allowed as a first charge against it. The balance, distributed on the basis of parish expenditure on medical relief, significantly reduced the benefits of the grant to the Highlands, which had few poorhouses and where relief was primarily outdoor.

The final general point raised was the *partial operation of the Insurance Act* in the non-industrial Highland counties where employment was often seasonal and temporary, placing most workers outside the compulsory terms of the Act and, as was discussed in Chapter 4, unable to afford to pay voluntary contributions.

Within the context of the preceding conditions the Committee concluded that medical provision was unlikely to be adequate. They did consider however that the situation was not necessarily as a result of too few doctors *per se*, as doctors often did not have a high consultation rate, but rather that the distribution of them throughout the Highland counties was uneven. John Jeffrey, Secretary of the National Health Commission, Scotland, in his evidence to the enquiry, stated that bringing additional doctors to certain areas might have resulted in doctors leaving as a result of their

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<sup>19</sup> *Dewar Report*, p.11. The Committee acknowledged that population had increased in some areas of the Highlands and Islands, mainly in the western Isles.

<sup>20</sup> *Dewar Report*, p.12.

<sup>21</sup> *Dewar Evidence*, Q.16,460, p.342.

salary being reduced. 'My objection to having another doctor there [Lochmaddy] is that you would cut into Dr Mackenzie's salary and he might leave'.<sup>22</sup> However, in many areas the difficulty of covering the large distances and terrain of the Highlands and the social and welfare conditions doctors faced discouraged many medical men from settling in the Highlands and prevented them from providing a professional service. The conditions faced are illustrated in the following example:

At Swindon, where the railway works are, and where they have an extraordinary developed medical system, one man attends 5000 people. They have two chief medical officers at about £1500 and two assistant officers at about £800 and £1000 and a number of men at £500, and they attend about 5000 people each with thorough efficiency. But they are all within a few miles from the furthest of their patients. There are endless rows of cottages. They are almost like hospital wards. In the island of Lewis, with a population of 30,000, one doctor had responsibility for '7000 in a parish ...twenty seven miles long by six or seven miles wide', with 'only a motor cycle and no nursing service except one or two women who are not skilled midwives'.<sup>23</sup>

Part III of the Report addressed conditions affecting the adequacy of Medical services.

#### *Motor locomotion*

Doctors used a variety of means to carry out their work, many having no alternative but to walk. Few doctors had their own means of transport, except perhaps a bicycle, and were often forced to hire a horse and cart, often with a considerable walk over rough ground to reach the patient. The average distance between the seven doctors on Skye and their patients was 13 miles; from Bracadale it was 16 miles. In addition, many parishes included inhabited islands, which depended on the doctors on mainland Skye for medical care. The cost of the doctors' travel could include, for an ordinary visit (a prolonged visit cost more) the hire of a cart at 1s. per mile, plus 3d. per mile for the driver, which could cost the patient up to 15s.; the hire of a motor, 2s. per mile plus 3d. for the driver.<sup>24</sup> The doctor at Garrynahine was responsible for a large district on the mainland and the islands to the west. At the time of the enquiry he had recently purchased a motor bicycle and it was reported that he did not know how he had managed without it.<sup>25</sup> Most witnesses agreed that 'motor locomotion by land and

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<sup>22</sup> Dewar Evidence, Q.727-8, p.25.

<sup>23</sup> Dewar Evidence, Q.23, pp.160-161.

<sup>24</sup> Dewar Evidence, Q.16,460, p.341.

<sup>25</sup> Dewar Evidence, Q.361, p.11.

water' was the most effective method of overcoming this problem. Before motor boats were available the doctor in Lerwick was often unable to visit Bressay due to the weather.<sup>26</sup> A car, it was believed, would double the work capacity of a doctor, assuming, of course, that the roads were suitable, which was not always the case.<sup>27</sup> Dr Taylor of Yell was one of the first doctors to use a car. (See Plate 8, Dr Taylor and his early car.)

### *Telephones*

The advantages of having a telephone service between doctors' homes and post offices were clear in the evidence to the Committee. Telephones were already in use in certain parts of the Highlands, mainly in conjunction with the telegraph system but few were available to doctors. The potential advantage of being able to speak to patients before a visit, allowing doctors to take the correct appliances and drugs was stressed. As earlier in the century, for many, communication was by telegraph which was 'cumbersome and unsatisfactory.'<sup>28</sup>

### *Income*

It had been anticipated by the enquiry that doctors' incomes would be low but the Returns of the Query Schedules showed that many doctors were earning levels 'well below the level of income tax'. From that they had to pay their living expenses and many were also supporting a family. In the initial Query Schedule the Committee requested: 'the gross amount of... income from all sources, and... net income after deducting expenses and such items as house rent'. (See Appendix 3, Return of Information from Medical Practitioners, 1912.)

The Return Of Information from Medical Practitioners showed that of forty-seven doctors who provided the information, twenty-eight were earning an average gross income of £200, which left, after rent and travelling expenses had been deducted, a net annual income of £120. This put the average net income of the forty-seven doctors just over the tax limit. The lowest figure given was £100 gross income, which gave the doctor a net weekly wage of between a pound and thirty shillings.<sup>29</sup> This can be contrasted with incomes of £800 to £1000 a year, which the medical profession could

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<sup>26</sup> *Dewar Evidence*, Q.6648-52, p.150.

<sup>27</sup> *Dewar Evidence*, Q.7756, p.170; Q.6531-2, p.148; Q.1390, p.45.

<sup>28</sup> *Dewar Report*, p.14.

<sup>29</sup> *Dewar Report*, p.14.

make in Lancashire and Yorkshire.<sup>30</sup> Doctors' salaries were dependent on parish salaries and fees from private practice. Public salaries varied considerably both regionally and locally. Local variation is illustrated in the following Orkney parishes:

**Table 5.4 Variations in doctors' public salaries in the parishes of Orkney County**

Parish	Pop.	Salary	
		£	s
Birsay & Harray	1772	18	16
Cross & Burness	1312	56	5
Eady	559	70	0
Evie & Rendall	955	95	0
Firth	693	8	0
Holm	763	8	0
Hoy & Graemsay	393	paid by fees	
Papa Westray	258	25	0
South Ronaldsay	2395	30	0
Shapinsay	718	30	0
Stromness	2346	35	0

**Source:** *Dewar Report*, Q.5056-5070, pp.122-123.

Considerable disparity is evident within a relatively small area. The parish of Firth, with a population of 693, paid £8 to its medical officer, while the parish of Evie and Rendall with a population of 955, paid £95. The explanation for the disparity was that in the case of Firth the doctor stayed in Kirkwall, medical provision easily provided without a resident doctor, and therefore was not dependent solely on his income from that parish. He was paid a sum relevant to the number of paupers in the parish. Evie and Rendall had a local doctor, and it was necessary therefore to adjust the salary accordingly, to enable the doctor to make a living.

Although information on private fees is more scarce, it was clear that they were also a potential source of income to supplement income from public duties. They were however extremely insecure as often payment was not forthcoming from patients. One doctor considered that 'if (he) had as much for every person (he was) supposed to be medical officer to as (he) got for the Parochial Board... (his) income would be about three times what it (was)'.<sup>31</sup> A consequence of low, insecure incomes was that doctors were unable to save or provide for old age or retirement, lengthening considerably the working life of a doctor practising in the Highlands and Islands. Consequently doctors

<sup>30</sup> *Dewar Evidence*, Q.7228, p.160.

<sup>31</sup> *Dewar Evidence*, Q1574, p.50.

continued working 'long after he (was) physically unfit to discharge his duties efficiently'.<sup>32</sup> The inability of medical practitioners to retire with a realistic pension was not simply confined to the Highlands. The *British Medical Journal* reported in 1911 that a doctor would require to save £50 a year for 20 years to build a pension pot of £1,463, which would provide £128 per annum, or almost £2. 10s a week income at 60 years of age. Such a level of saving was beyond the means of the majority of practitioners.<sup>33</sup>

### *Security of Tenure*

A continuing feature of the welfare of the medical profession in the Highlands which affected the adequacy of medical service was the recurring question of security of tenure, which remained unchanged throughout the nineteenth century and first decade of the twentieth century. Unlike medical officers of health, parish medical officers lacked security of tenure, which was believed to prevent 'good' medical men from accepting posts in the Highlands. Doctors were thus vulnerable to the actions of parish councils who had the power to remove them from office and had no right of appeal available to them.

It was reported:

It has been a long-standing grievance with Parochial Medical Officers that whereas the County Medical Officer of Health, the Poorhouse Medical Officer, the Sanitary Inspector, and the Inspector of Poor, can be dismissed only by or with the sanction of the Local Government Board, the Parish Council has absolute power of dismissal over the Parochial Medical Officer and cases were cited where the Council appear to have used the power harshly.<sup>34</sup>

Doctors were subject to dismissal for being accused of being inefficient in their duties, for disagreeing with the parish council, for prescribing drugs, food or appliances which the parish council did not consider necessary, for being unpopular with the community and on other 'very slender grounds'. In the Parish Council of Farr 'the doctors (had) been warned again and again (by the Local Government Board) not to apply' for the post of Medical Officer. The Secretary of the National Health Commission, John Jeffrey, felt that 'if he had been a medical man (he) would not on

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<sup>32</sup> *Dewar Report*, p.14.

<sup>33</sup> *BMJ*, 15 July 1911, p.127.

<sup>34</sup> *Dewar Report*, p.14.

any account have accepted a situation under the control of such a body'.<sup>35</sup> This indicates that, in some cases at least, this issue was serious enough to warrant concern. The relationship between Parish Medical Officer and Parish council was generally found to be cordial, but the occasional instances of harsh treatment had engendered a feeling of distrust among the medical profession, which the committee felt had reduced the quality of the service in parts of the Highlands.

The experience of the parish of Kildonan in Sutherland illustrates the difficulties which could arise. Prior to 1899 one doctor served as parish medical officer for 17 years. Although no fault appeared to have been found with his medical skills, he was asked to resign, refused, but eventually did resign his appointment. Although few facts are available there is evidence that the Parish Council were believed to be in the wrong. Following his resignation the parish had five doctors between 1899 and 1912. The Parish Council advertised the post on each occasion in secular newspapers such as the *Scotsman* or *Glasgow Herald*. Each advertisement was countered by opposing adverts placed by the British Medical Association requesting applicants to first contact them before applying for the position, presumably to warn of the conditions likely to be met there. While the doctor may have been considered to be inefficient this was not stated to the Dewar Committee and the British Medical Association did not take similar action on every case of dismissal. Injustice was clearly believed to have taken place and intransigence was a feature of the parish council. It refused to employ the services of the local Sutherland nurse for pauper nursing because they 'had no voice in the management of the nurse', indicating rigid inflexible attitudes.<sup>36</sup> Other instances of uncompromising parish councils, with whom the parish doctors had to deal, occurred throughout the Highlands and Islands.

An aspect which caused concern to parish councils, on the other hand, was that security of tenure could result in difficulty in removing inefficient doctors from office. 'I think it is a calamity for a district to have fixity of tenure to a man who is inefficient.'<sup>37</sup> If this is taken at face value, accepting that strained relations between doctors and parish councils did occur, it suggests that supplies of doctors prepared to work in the Highlands were not restricted and that the quality of the work performed

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<sup>35</sup> *Dewar Evidence*, Q.830, p.28.

<sup>36</sup> *Dewar Evidence*, Q.9337-9345, p.198. Evidence of J. Fraser, Chairman of the Parish Council of Kildonan, Sutherland.

<sup>37</sup> *Dewar Evidence*, Q.1720, p.54. Evidence of Dr J. Leach, doctor in Beauly, Inverness.



was an important factor. This is also borne out by the above example; despite the efforts of the British Medical Association, the parish council did succeed in filling the post, although the doctors did not remain in office for long periods.

### *Housing*

An important issue which was reported throughout the enquiry was that the persistent lack of provision and poor quality of housing for doctors. Despite the fact that parish councils were very keen to keep their doctors, and were legally bound to provide medical care for the registered poor, little effort was made to ensure adequate accommodation. The most reasonable explanation was that, in most instances, financial restrictions prevented them from so doing. Most parish councils believed their rates burden was already too heavy, and if little local support was available or forthcoming, then there was little they could do.

The Committee noted with some perplexity the number of manses of good quality which were readily provided in many districts, while doctors housing was more often of a poor quality, or lodgings. For example, in Glendale parish, Skye, twelve ministers were supported by the parish while the only doctor struggled to make a living.<sup>38</sup> Likewise, in Glenlyon in Highland Perthshire ministers outnumbered doctors by nine to one. It was recorded that 'an appeal to the public for money to buy a doctor's house ...would get nothing, while (they) could raise hundreds of pounds for manses.'<sup>39</sup> This was also the case in Mid-Yell, Shetland where the Committee noted that it was 'extraordinary ... (that the parish's eleven ministers) ...should have all those manses and yet not be able to provide a good doctor's house'.<sup>40</sup> The Duchess of Atholl also noted this issue in her book and noted that Unst had 'four churches and four well-built manses' while Dr Saxby's house 'lacked a bathroom'.<sup>41</sup> In many instances doctors were forced to provide their own houses and surgeries, sometimes by building them.<sup>42</sup> Dr. H.P. Taylor from Mid Yell had a 'fair' house, but 'put up a consulting room and a surgery at (his) own expense'.<sup>43</sup> Although this was an alternative it was not always

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<sup>38</sup> *Dewar Evidence*, Q.15,101, p.314.

<sup>39</sup> *Dewar Evidence*, Q.7718, p.169.

<sup>40</sup> *Dewar Evidence*, Q.6976, p.155.

<sup>41</sup> *Working Partnership*, p.69.

<sup>42</sup> *Dewar Evidence*, Q.19498, p.389.

<sup>43</sup> *Dewar Evidence*, Q.6969, p.155.

considered a safe investment, some doctors fearing the house could be taken off them if they were replaced by another doctor.<sup>44</sup>

A more unusual instance occurred on Papa Westray in Orkney, where in 1914 the parish council was prevented from building a house for the resident doctor, despite having raised sufficient funds locally. Mr. Cathcart Wason, M.P. for Orkney and Shetland stated in a House of Commons Official Report on the National Insurance Bill of the inhabitants:

It has long been their ambition to get a doctor's house, but, despite the fact that all the money necessary has been placed at the bank, the landlord refuses to give, sell, or feu them a piece of land. I have written to the Local Government Board a long and pressing letter, urging them not to prohibit those poor islanders even having a doctor in the island, although they have a stormy sea and a dangerous passage to cross before they can get to one.<sup>45</sup>

In this case the landlord was absent from the island and failed to appreciate the difficulties outlined above. It was 1928 before a doctor's house was secured on the island, partly due to the steep rise in costs after the war. Until that time the lack of a permanent residence for a doctor deterred candidates and 'was a serious grievance and medical officers (made) their stay short.'<sup>46</sup> The Papa Westray case was also reported by Cathcart Wason in a letter to the *British Medical Journal*, where he also claimed credit, supported by Mr McPherson, MP for Ross and Cromarty, for persuading the Chancellor of the Exchequer to establishing the Dewar Committee.

### *Lack of holidays and professional development*

Doctors in the Highlands were seldom able to take a holiday. The principal reason was that their income did not permit the cost of a locum, if one could be obtained, which was by no means certain. Dr. J. Leach, a doctor in Beaully, was eighteen years in practice in that district and 'never (got) any holidays'. This was considered a serious problem. Firstly, doctors could not relieve the strain, both physical and mental, of arduous Highland practices and secondly, they were unable to take post-graduate courses to keep abreast of new developments in medicine. It was considered that a doctor who had been unable to attend post-graduate courses for ten years would be

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<sup>44</sup> *Dewar Evidence*, Q.19500, p.389.

<sup>45</sup> OIA, CO6/11/13, *House of Commons Official Report*, 13 November 1911, National Insurance Bill; *BMJ*, Correspondence, 8 February 1913.

<sup>46</sup> OIA, CO6/11/14.

lacking in up to date medical knowledge and unless he was able to keep abreast of new developments at home 'would not even know the terminology of disease'.<sup>47</sup> The implications for the adequacy of medical provisions are clear. Patients in the Highlands therefore, were at greater risk potentially of receiving poorer treatment than their counterparts in the Lowlands. Evidence from the Medical Registers suggests that doctors in the Highland counties held fewer postgraduate qualifications than doctors in the Lowlands.

**Table 5.5 Numbers of doctors in Orkney, Sutherland, East Lothian and Selkirkshire with higher qualifications, 1900-1910**

Date		Orkney	Sutherland	East Lothian	Selkirkshire
1900	Number of Doctors	23	12	26	12
1910	No of doctors holding higher qualifications	3	2	8	3
1900	Number of Doctors	23	12	29	10
1910	No of doctors holding higher qualifications	3	2	16	2

**Source: Statistics compiled by Dr John Brims from the *Medical Directory*, 1900, 1910.**

The Committee reported thus that medical attendance could not be regarded as adequate, not resulting from too few doctors, but because of poor travelling arrangements, 'defective means of locomotion and communication' and the conditions affecting the welfare of the profession.<sup>48</sup>

The inadequacy did not arise therefore, in the main, from a shortage of doctors, although in some districts it was believed that more doctors were required. For example, in Carloway, in the parish of Uig, near Stornoway, one doctor attended to 4000 people over a wide and difficult area.<sup>49</sup> A remote location was not always the reason for a perceived need for more doctors; in Argyllshire, where conditions of

<sup>47</sup> *Dewar Evidence*, Q.1725, p.54.

<sup>48</sup> *Dewar Report*, p.13.

<sup>49</sup> *Dewar Evidence*, Q.11,597, p.245.

remoteness were not as severe as other areas, it was also felt that to improve medical services substantially an increase in doctors was desirable.<sup>50</sup>

The apparent requirement in some areas for more doctors did not arise as a result of doctors being overworked in terms of the number of cases they had to attend. In many areas a doctor's workload was relatively light. The main problem was more often the difficulty and time taken travelling to and from patients' residences. The Medical Officer of Health for Sutherland stated that although doctors were paid extra by parish councils, relative to the number of paupers, this was still insufficient to live on and pay ordinary expenses. Therefore the question of expense was always uppermost in his mind....and he must reach his patient in the cheapest way possible and as seldom as he conscientiously can.<sup>51</sup>

The Committee concluded therefore that inadequate salaries, pensions and holidays and insecurity of tenure, together with the difficulties of communication and finding an acceptable house to live, all affected the general effectiveness of the medical services provided. Section IV of the Report demonstrated the inadequate nature of medical attendance by citing high numbers of uncertified deaths and illness not attended, as disclosed by school medical inspection and in the continuing use of patent medicines and traditional cures.

#### *Uncertified deaths*

The preceding evidence demonstrated clearly to the Committee that existing medical attendance in the Highlands was unsatisfactory. The most 'conclusive evidence' for this was the high rate of uncertified deaths in the Highlands, a consequence of a doctor not being called in cases of serious illness or to certify the death. In 1881 the average percentage of uncertified deaths to total deaths for Scotland was 10.9%, representing 7863 deaths. By 1910 that number had fallen to 1396, or 1.9%. Within the Highland Counties and parishes however, the rate was significantly higher.

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<sup>50</sup> *Dewar Evidence*, Q.19,353, p.386.

<sup>51</sup> *Dewar Evidence*, Q.8547, p.182.

**Table 5.6 Proportion of uncertified deaths in Highland Counties, 1909 and 1910**

	Argyll	R&C	Inv'sh	Shetland	Orkney	Caithness	Sutherland
Total deaths	1132	1136	1325	397	452	526	346
Certified	1039	881	1115	301	419	500	346
causes							
Uncertified	93	255	210	96	33	26	90
causes							
% in 1910	8.2	22.4	15.8	24.2	17.3	4.9	26
% in 1909	9.8	24.9	17.5	20.3	10.6	3.8	25.9
% mean for 5 yrs. 1905-9	8	24.5	18.3	22.3	11.2	6.5	24.6

**Source: Dewar Evidence, Q.257-277. (Presented by J Patten MacDougall from his Annual Report as Registrar General, Scotland.)**

The total number of uncertified deaths in the Highland counties during 1910 were 803, representing 57% of the total number of uncertified deaths in Scotland. At parish level the percentage of uncertified deaths rose significantly. In the County of Inverness, the percentage of uncertified deaths to the total number of deaths in the county in the years 1901-1911 was 29%; and in the case of 10 parishes it ranged from 41% in the parish of Snizort to 59% in the parish of the Small Isles, an average of 48% for the 10 parishes. Therefore, out of a total of 3825 people who died, 1821 had not had medical attendance prior to their death.<sup>52</sup>

Among the mainland registration districts of Ross the statistics also reveal a serious situation.

**Table 5.7 Percentage of uncertified deaths in parishes of Sutherland**

Parish	% uncertified deaths
Sheildaig	78.1
Coigach	80.9
North Gairloch	46.3
Lochbroom	40.4
Kincardine	33.9
South Gairloch	32.8

**Source: Dewar Report, Part IV, section 1, p.17.**

In Coigach parish, Lochbroom, only nine deaths of a total of 148 were certified between 1901 and 1910 and of 12 pauper deaths in that parish only one was certified, suggesting that the parochial system was generally ineffective in that area.<sup>53</sup> In Skye

<sup>52</sup> *Dewar Report*, p.16.

<sup>53</sup> *Dewar Evidence*, Q.709, p.24.

the high percentage of uncertified deaths was attributed mainly to the lack of medical attendance and was perceived as the most striking proof that medical provision was inadequate, which the following table illustrates. In 1911 50% of deaths in the parish of Stenscholl, numbering 34, were uncertified <sup>54</sup>

**Table 5.8 Deaths registered in 11 Skye registration districts ‘for past five years’ to 31st December 1911**

	Paupers	Total Deaths	Number Uncertified	%
North Snizort	7	45	15	20
South Snizort	14	94	51	54
Stenscholl	4	68	34	50
Kilmuir	11	73	33	46
Portree . . .	39	171	39	23
Raasay . . .	1	33	16	50
Sleat . . . .	19	113	12	9
Minginish . . .	7	28	11	40
Struan . . .	7	28	9	33
Strath. . . .	14	167	19	11
Duirinish . . .	24	246	95	38
Waternish . . .	4	66	63	95
Total	151	1132	397	

**Source: Dewar Evidence, Q.16,460, p.343.**

Doctors were not called for a number of reasons. There was evidence of a general resistance to calling the doctor for minor ailments, resulting in many illnesses not being detected early enough and becoming chronic or untreatable. Similarly, ‘infectious diseases, unless the symptoms [were]very alarming, are often allowed to go too far before the doctor is called, infecting others before the diagnoses is made’. The cost of the doctor’s fee, which might include travel costs for those at a distance, as has previously been discussed, was a major inhibiting factor in the failure to call the doctor. In the case of illness or debility in older people, there was less urgency to call the doctor and after death occurred, a view that they had simply died of old age and that there was no point in calling the doctor. The statistics provided to the enquiry by Dr Donald Murray, Medical Office of Health for Lewis District, support the last

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<sup>54</sup> *Dewar Evidence*, Q.16,460, p.343.

issue. In 1911 in Lochs, Barvas, Uig and Stornoway landward, there were 96 uncertified deaths, the majority over the age of 65.<sup>55</sup>

**Table 5.9 Age of death and number of uncertified deaths, Lochs, Barvas, Uig and Stornoway landward, 1911**

Age	No of uncertified deaths
Under 1 year	9
5-15	8
15-25	1
25-45	2
45-65	8
Over 65	68

**Source: Dewar Evidence, Q.10,488, p.220.**

#### *School medical inspection*

School medical inspection showed ‘abundant evidence as to the existence of disease and physical defects in school children’. One of the most urgent defects was caries of the teeth; ‘a child of thirteen years of age (having) on average six decayed teeth’.<sup>56</sup> In Portree district medical inspection revealed that a high proportion of school children had decayed teeth. Other conditions included ‘enlarged tonsils, swollen glands and adenoids’ and cases of malnutrition.<sup>57</sup> Concern was expressed that the lack of medical care, diagnosis and treatment presented the risk that such conditions could give rise to ‘chronic ill-health’ in later life’.<sup>58</sup> The benefit of follow-up nurse visits to follow up treatment and educate parents in their homes was also considered.<sup>59</sup>

#### *Substitutes for medical attendance*

Other evidence of the inadequacy of medical treatment was the use of substitutes for medical attendance. This included the use of patent medicines, which were cheaper than prescribed medicine and sales of which exceeded that supplied by doctor's prescription. A chemist from Thurso estimated the proportion as high as five to one. This was attributed to ‘the want of doctors in the various districts’.<sup>60</sup> The persistence also of traditional ‘cures’ and superstitious practices in remote areas had similar

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<sup>55</sup> Dewar Evidence, Q.10,473-10,490, p.220.

<sup>56</sup> Dewar Report, p.19.

<sup>57</sup> Dewar Evidence, Q.16,460, p.343.

<sup>58</sup> Dewar Report, p.19.

<sup>59</sup> Dewar Evidence, Q.17,636-640, p.369.

<sup>60</sup> Dewar Report, p.19.

foundations.<sup>61</sup> Some evidence was presented to the Committee that some nurses, operating without the oversight of a doctor, in remote areas may have adopted 'the role of medical practitioner' and used traditional cures, though the practice was not considered to be widespread.<sup>62</sup>

The Committee concluded that the evidence provided to them indicated that the existing medical attendance in the greater part of the Highlands and Islands was inadequate and 'would have a prejudicial effect on the welfare of the people'.<sup>63</sup> Part V of the Report examined nursing provision, which was found by the enquiry to be one of the most vital factors affecting the effectiveness of medical provision.

### *Provision of Nurses*

Both doctors and non-medical witnesses were unanimous 'that no matter affecting the welfare of the people of the Highlands and Islands is more urgent than the provision of an adequate supply of trained nurses'.<sup>64</sup>

Lord Lovat, when questioned on the role of nursing, was even more adamant stating 'The medical salvation of the Highlands lies... in organised nursing'.<sup>65</sup> In 1900 there were 225 trained Jubilee nurses working in Scotland, only 32 of them located in the Highlands, in the counties of Argyll (24), Caithness (3), Cromarty (1), Inverness (3) and Shetland (1). Of the 32, seven nurses were located in the burghs of Tobermory, Campbeltown, Inverary, Oban, Stornoway and Lerwick, leaving only 25 in the rural parishes.<sup>66</sup> By 1912 the twenty fourth report showed that of 232 Jubilee nurses in Scotland 49 were working in the Highlands, 13 of whom worked in the burghs. 36 therefore were located in the rural parishes, an increase of only 11 trained nurses in 12 years.

In addition to Jubilee nurses, there were also Govan nurses, who had more limited training in the Govan Training Home, in midwifery. In the eight years prior to the enquiry 33 nurses were sent to the Highland districts of Sutherland (7), Argyll (4),

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<sup>61</sup> The breadth of traditional cures and customs in the Highlands is detailed in M Beith, *Healing Threads*, Edinburgh, 2004 and in sections of Ann MacKenzie, *Island Voices: Traditions of North Mull*, Edinburgh, 2002.

<sup>62</sup> *Dewar Report*, p.20.

<sup>63</sup> *Dewar Report*, p.20.

<sup>64</sup> *Dewar Report*, p.20.

<sup>65</sup> *Dewar Evidence*, Q.2312, p.67.

<sup>66</sup> Queen's Nurses in Scotland, *Twelfth annual report of the Council of the Scottish Branch of the Queen Victoria's Jubilee Institute for Nurses*, 1900.



Ross-shire (4), Inverness-shire (3), Perthshire (2), Hebrides (7) Mull (1).<sup>67</sup> The supply of Govan nurses was intended to reduce the number of ‘handy’ or ‘skilly’ women, untrained local women who delivered babies. Some areas, such as Benbecula, had no qualified nurse, only an elderly unqualified woman. Such practices, often a doctor was not available, often resulted in cases of puerperal fever and infantile tetanus and led to increased infant mortality.<sup>68</sup> As well as maternity skills nurses were invaluable in remote areas and island communities, such as Fair Isle where the doctor was at some distance from the population or was not available. They also provided instructions on hygiene, diet and child nutrition and often stayed with the family where they could impart their knowledge and skills. The doctor in Uig stated ‘A nurse, in many cases, is far more essential than a doctor’. They could also follow up school inspections.<sup>69</sup>

The provision of skilled nursing in the Highlands, as in the rest of Scotland, also relied on county and parish council funding and, less often in the Highlands, the voluntary effort of individual benefactors’ and ‘philanthropic agencies. (though Argyllshire Nursing Association funded 31 nurses throughout the county).<sup>70</sup> In the Highlands some estate landowners also provided nursing services to tenants, such as that provided by Mrs Mackintosh of Mackintosh, who initially provided nurses during a diphtheria epidemic in Lochaber and subsequently provided two cottage nurses and a trained Jubilee nurse in Lochaber and in Strathdearn.<sup>71</sup> Nurses, of course, whoever employed or funded them, faced the same conditions as doctors, including long journeys to patients and poor housing.<sup>72</sup>

Part VI of the Report addressed hospital provision, ‘ a question, which... must be regarded as particularly vital to the adequacy of medical provision in the Highlands and Islands’.<sup>73</sup>

### *Provision of Hospitals*

Table 5.9 shows that in 1912 only twenty hospitals existed in the Highlands and Islands. The largest hospital was the Northern Infirmary in Inverness, with 68 beds.

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<sup>67</sup> One nurse was also sent to Forfar, not in the Highlands. *Dewar Evidence*, Q.23,319, p.486.

<sup>68</sup> *Dewar Report*, p.22.

<sup>69</sup> *Dewar Report*, p.24.

<sup>70</sup> *Dewar Evidence*, Q.252, p.7.

<sup>71</sup> *Dewar Evidence*, Q.2238-2242, p.65.

<sup>72</sup> *Dewar Report*, p.24.

<sup>73</sup> *Dewar Report*, p.25.

The Gilbert Bain hospital in Lerwick was opened in 1902, near the site of the original isolation hospital, opened in 1841. (See Plates 9 & 10, the opening of the Gilbert Bain Hospital and the Isolation Hospital.) The nineteen others had an average of eleven beds. Many areas were without even basic hospital provision and the enquiry stressed that, for several inter-related reasons, this level of provision was inadequate.

**Table 5.10 List of General Hospitals in the Highlands and Islands, 1912**

County Of Argyll:	
Campbeltown Cottage Hospital	12 beds
Dunoon Cottage Hospital	12 beds
West Highland Cottage Hospital	22 beds
County Of Caithness:	
Bignold Cottage Hospital, Wick	13 beds
County Of Inverness:	
Belfort Hospital, Fort William	18 beds
Bute Hospital, South Uist	10 beds/2 cots
Foyers Hospital, Foyers	2 beds
Gesto Hospital, Edinbane, Skye	12 beds
Invergarry Cottage Hospital,	
Invergarry	2 beds
John Martin Hospital, Uig, Skye	6 beds
The Northern Infirmary, Inverness	68 beds
Tarbert Cottage Hospital, Harris.	2 beds
2 cots	
County Of Orkney:	
Balfour Hospital, Kirkwall	15 beds
Perth, Highlands of-	
Irvine Memorial Nursing Home, Pitlochry	9 beds
1 cot	
County Of Ross And Cromarty:	
Cromarty Cottage Hospital	10 beds
Lewis Hospital, Stornoway	12 beds
Ross Memorial Hospital, Dingwall	17 beds
County Of Shetland-	
Gilbert Bain Memorial Hospital, Lerwick	21 beds
County Of Sutherland	
Lawson Memorial Hospital, Golspie	10 beds

**Source: Dewar Report, Appendix No. 3, 1912, Cd.6559, pp.51-2.**

The poor sanitary condition of houses in Highland districts, particularly in the Hebrides, made domiciliary treatment and nursing care of common, less serious

illnesses and diseases difficult and impractical, given the lack of sterile conditions. A local hospital, even of modest proportions, was therefore considered a necessity in most areas. This was not limited to the most isolated, remote areas. Dr. Hunter, a G.P. practising in Lochgilphead, a relatively accessible district, was recorded as saying:

That is one great want: it would be a great advantage to our district to have a cottage hospital, even a small one. It need not be a fully equipped one, if it was only a place where you could get the patients to, because in some of these wretched houses you can do nothing.<sup>74</sup>

As well as improved hygiene an added advantage of small local hospitals was believed to be the consequent ease of access for the doctor. In the remoter, sparsely populated areas and insular districts without a resident doctor, it was often difficult or impossible for the doctor to visit a patient on a regular basis. A small hospital situated close to the doctor's residence, with a competent nurse could considerably improve patient care and allow more efficient execution of the doctor's time. The main advantages envisaged was in maternity care, particularly in potentially difficult confinements. It was noted that one of the main reasons for the founding of the Belfort Hospital in Lochaber was for:

the wives of poor shepherds in one or other of the said parishes living at a distance and about to be confined for the purposes of confinement and other treatment.<sup>75</sup>

Evidence to the enquiry indeed confirmed the perceived need for more hospitals in the localities of the Highlands but also indicated that smaller informal hospitals may have been more acceptable as local people often had a fear, not only of being sent away to hospital in the cities, but also of the idea of hospitals in general. 'They don't like the idea of a hospital, as they think they are going to die if they go there'.<sup>76</sup>

To enable the doctor to perform urgent surgery some form of small local cottage hospital was deemed necessary by medical witnesses. (A list of medical witnesses to the Dewar Enquiry is at Appendix 5.) One doctor from North Uist found himself operating on a strangulated hernia in a hut, with chloroform administered by a clerk,

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<sup>74</sup> *Dewar Report*, p.25.

<sup>75</sup> *Dewar Report*, p.25.

<sup>76</sup> *Dewar Evidence*, Q.20,990, p.421.

the only light provided 'by a tallow candle held by a neighbouring crofter, who fainted during the proceedings'.<sup>77</sup>

Most of the existing hospital provision was located in the most populous areas therefore not easily accessible to many patients, even if they were able to withstand a rigorous journey by boat or trap. It was also considered that the erection of small cottage hospitals could help overcome the problem of accommodation for doctors and nurses. However, even where hospitals existed, it was felt that they often did not run to their full potential due to differences between the doctors and those running the hospitals. Such a dispute between the doctor and the governors was believed to be hindering the efficient running of The Lewis Hospital.<sup>78</sup>

The provision of tuberculosis hospitals was also considered, due to the high death rate from the disease, particularly in Lewis, and institutional provision for the treatment of the disease non-existent. Although some benefit was provided under the terms of the Insurance Act for the treatment of tuberculosis, the majority of the population were not covered. Poor housing, hygiene, food and uncertain employment exacerbated the situation. The most effective solution to the inadequate provision of tuberculosis hospitals was held to be a special subsidy for this purpose.

Together with the lack of hospitals, dispensaries and druggists were rare. Part VII of the Report outlines the difficulties faced by doctors who were required to provide both medicines and medical appliances.

#### *Provision of Medicines and Medical Appliances*

The provision of drugs in the Highlands and Islands fell largely on the medical practitioners due to the lack of dispensing chemists in many localities. Medical graduates of Scottish universities were qualified pharmacists and thus authorised and licenced to supply drugs.<sup>79</sup> While this was a problem common to many country areas, the degree of remoteness and isolation of many communities in Highland and insular districts, accentuated the problem.

To overcome this difficulty doctors themselves supplied and provided drugs, often placing great strain on their finances. A Lewis doctor claimed 'It is one of the biggest

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<sup>77</sup> Dewar Evidence, Q.13,818, pp.287-8.

<sup>78</sup> Dewar Evidence, Q.10,954-10,964, p.230.

<sup>79</sup> Dewar Evidence, Q.11,674, p.247.

expenses to me in this island. It is an awful drain on my purse'.<sup>80</sup> Doctors' incomes were poor and difficulty was often experienced in keeping an adequate stock of drugs, a situation which was intensified as doctors were expected to treat and supply drugs for the uncertified poor 'whether they pay or not'.<sup>81</sup> By not receiving payment for medical attendance therefore, doctors were not only poorly remunerated for their time expended but also for drugs prescribed.

Medicines were often conveyed to patients by messenger or post and doubts were expressed as to the freshness and quality of the prescribed drugs, largely dependent on the degree of remoteness and ease of obtaining drugs, and the financial circumstances of the doctor.<sup>82</sup> In some areas however, it was traditional for the doctor to provide medicines as part of his treatment and included in the charges giving rise to complaints by druggists, that doctors were, in some districts, encroaching on their sphere. The majority of Highland doctors however, expressed a preference for a qualified druggist in a district, if one was available. To overcome the problem of non-availability, drugs depots were established in some areas. By 1912 however, the provision of dispensaries was growing and, as has been seen earlier, the proportion of patent drugs as opposed to prescribed drugs was increasing.

Having examined in some detail the obstacles to an effective medical service Part VIII of the Report outlined the existing medical provision, each of which operated in isolation, with little co-ordination, to assist them with their general conclusions and recommendations.

### *Existing medical provision*

The medical services existing in 1911 were surveyed to determine how best to develop a scheme to improve the clearly inadequate service in the Highland and Islands. They comprised the public health medical service, the school medical service, the health insurance medical service, the Poor Law medical service, the general medical service and the specialised medical service.

### *Public Health Service*

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<sup>80</sup> *Dewar Evidence*, Q.11,521, p.244.

<sup>81</sup> *Dewar Evidence*, Q.2,624, p.76.

<sup>82</sup> *Dewar Evidence*, Q.11,518-521, p.244.

The Public Health Service, developed throughout the latter decades of the nineteenth century were required to appoint medical officers of health who were responsible for all aspects of health and, in particular, the management and domiciliary treatment of infectious disease and the provision of hospitals and convalescent facilities of the Highlands and Islands. Local doctors were often employed as parish medical officers of health, though salaries were often low, and nurses were employed in some parishes for infectious diseases, though much evidence was provided demonstrating that the system lacked effectiveness in dealing with infectious disease. 52 deaths from whooping cough were recorded in Lewis in 1910. The system was under increasing stress following compulsory notification of tuberculosis.<sup>83</sup> ‘At the present moment your nursing system for infectious diseases is quite inadequate’.<sup>84</sup>

### *School Medical Inspection*

By 1911 all Highland county Education Committees, with the exception of Orkney and Shetland, had employed school medical officers, under the authority of the Scotch Education Department. Although progress was made in the detection of disease and debility, the follow up treatment was poor, exacerbated by the lack of specialist services, some of which were provided for boarded-out pauper children from Lowland Scotland, ‘there was no evidence of treatment for poor non-pauper native children’. A Treasury grant provided little to the Highland counties but was viewed as a positive development.<sup>85</sup>

### *Insurance Medical Service*

The service under the National Insurance Act was not yet in operation during the period of the enquiry and the numbers of insured were not known. It was noted that the effective running of it would be hindered by all the factors which prevented an adequate medical service, for persons insured under the act.

### *Poor Law Medical Services*

Medical services under the Poor Law included the provision of medical attendance for the registered poor, old age pensioners, pauper lunatics and the vaccination of defaulters by parish medical officers. Although the MRG encouraged the employment

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<sup>83</sup> *Dewar Report*, p.31.

<sup>84</sup> *Dewar Evidence*, Q.10,592, p.223.

<sup>85</sup> *Dewar Report*, p.32.

of parish medical officers throughout the later decades of the nineteenth century, the reduced proportion payable to parishes, following nursing in poorhouses being made a first charge on the grant, placed a high burden on the rates.

Although poor law medical officers' salaries were often low, they frequently were disproportionate to the number of registered poor in a district. The requirement to provide visits to pauper lunatics also placed a heavy obligation on the rates as did the requirement to vaccinate paupers, their children and defaulters, those who refused to vaccinate their children within six months of birth. As non-pauper patients were required to pay for vaccination, 'the majority of parents become defaulters' in the Highlands and Islands.<sup>86</sup>

The poor law medical service was key to the availability of medical treatment for the general population and was largely subsidised by local rates. Furthermore, the parish as a Medical Administrative Area was an entity which exercised much power over, not only the poor law medical services, but over doctors' private practice, and their perceived areas of professional jurisdiction, the parish. Parish doctors were not always situated in the best location for the majority of the population and doctors from neighbouring parishes were sometimes closer, leading to a conflict between the doctor resident in the parish and doctors in neighbouring practices, who they viewed as encroaching on their 'territory'. Furthermore, some parish councils also stipulated the fees doctors could charge for their private work. The medical areas therefore, did not always utilise to the best potential, the work that was available and provide the most effective services.

### *General medical practice*

General practice provided a means for parish doctors to increase their salaries and the report stressed the wide-range of skills and knowledge they required as general practitioners in the remote Highland parishes.

When it is remembered that a doctor practicing in a rural district has to be ready to perform the widely dissimilar specialised duties pertaining to the surgeon, obstetrician and physician in city practice, it will be recognised on the one hand how much responsibility and strain lie

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<sup>86</sup> *Dewar Report*, p.35.

upon him; and on the other, how much of varied skill is expected of him unaided.<sup>87</sup>

Evidence to the Committee suggested that a consequence of the above was a predominance of younger doctors developing their careers and older doctors who may have chosen the Highlands as ‘a last resort and harbour of refuge’. Although this may be a generalisation, it was agreed that the working conditions were unlikely to attract the best in the field. Doctors’ fees were often not paid by a poor population with little disposable income and voluntary medical clubs, designed to spread the costs for a family, were not generally successful in increasing doctors’ incomes for the same reasons. Subsidies from various Imperial grants, though providing some certainty of income, were gradually reduced throughout the period leading to the Dewar Enquiry. Given the difficulty of securing an adequate salary from private practice there was consequently a high turnover of doctors in some parishes.

#### *Specialised medical services*

Specialist services were virtually absent in the Highlands and Islands. Those deemed most important by witnesses were dentists and eye specialists, for adults and school children. In addition a pathology service was required to deal with infectious diseases, including diphtheria, typhoid and tuberculosis. In the treatment of infectious disease the ability to transport patients to hospital was crucial. Local authorities were required to provide ambulances for infectious diseases but there was no statutory requirement for ordinary illness. Medical and surgical consultation in the Highlands was also largely absent.

### **5.3 The conclusions and recommendations of the enquiry**

Following the conclusion of the enquiry the Dewar Committee were pressed to issue their report quickly and within a relatively short period the Report was published. It made impressive reading in the scale and breadth of detail it encompassed, not only in the standard of medical provision, but in all aspects of life in the Highlands.

Having examined the social and economic conditions and the nature, scope and quality of medical services in the Highlands and Islands, the Dewar Committee concluded that medical services were inadequate, poorly funded and that any improvement of the existing level of service could only be brought about by a

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<sup>87</sup> *Dewar Report*, p.37.



substantial government subsidy. It was clearly seen that medical practice for the general population of the Highlands and Islands was largely reliant on the Poor Law Medical Service but also that the income of poor law doctors bore no relation either to the work done or the responsibility involved. The subsequent discouragement to doctors to take up posts, or remain in employment in the Highlands, thus affected the quality and class of the medical service which was provided.

The principal conclusions drawn by the Dewar Committee on nursing provision was that not only were the number of nurses in the Highlands and Islands inadequate, but that the efficiency of the existing supply was impaired due to poor organization and co-ordination. While it was accepted that within the above limitations, nurses fulfilled the function of 'alleviat(ing) suffering and remov(ing) danger in sickness', greater resources were required for the nursing profession in the fields of maternity care, the following up of school medical inspection, hygiene and diet among the population and earlier detection of illness.<sup>88</sup>

A scheme for the consolidation of the various medical services by Leslie Mackenzie, which was part of the Committee's remit,

To advise as to the best method of securing a satisfactory medical service therein, regards being had to the duties and responsibilities of the public authorities operating in such districts.<sup>89</sup>

It was appreciated that the inadequacies of the medical service would not be removed simply by increasing the numbers of doctors, improvements in administration also required. The recommendation by Mackenzie was that local committees, encompassing a geographical area larger than the parish, which he considered too small, should be established. The local 'composite' committees would contain representatives from the various public medical services. The function of the local committees were to 'consider the local needs of the area' and develop local schemes for medical and nursing services which, it was envisaged, would be funded by an Imperial grant, which would be allocated by a central committee made up of the Local Government Board, the National Insurance Commission, the General Board of Lunacy and the Scotch Education Department. A Treasury representative was also

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<sup>88</sup> *Dewar Evidence*, Q.11,518-521, p.244.

<sup>89</sup> Minute of appointment, Treasury minute, dated 11 July 1912.

considered necessary and was to be appointed as Chairman of the new authority, to be called 'The HIMS Committee'.<sup>90</sup>

The Committee recommended therefore, that the development and co-ordination of Highland medical services be effected by an Imperial grant, administered by a new central authority and new smaller local authorities. The improvements were also to incorporate nursing and hospital provision and a specialist service.

#### **5.4 The importance of the: analysis and evaluation**

The evidence to the Dewar Committee suggested that little of substance had changed for the practicing doctor since the 1850s. While improvements to the infrastructure of the Highlands eased communication and travel for some and Imperial grants and public health developments assisted the treatment of infectious diseases, it also placed a heavy burden on parish rates.<sup>91</sup> There was most certainly a greater awareness of the conditions, but structurally, the ability of the rural medical practitioners to work and live in those areas had remained very similar since the Physicians' Enquiry of the early 1950s.

When the factors leading to the Dewar Enquiry are assessed it is clear that no one predominant issue alone was responsible for the changing perceptions of the Highlands. The land wars, in the Highlands and in Ireland, were played out in juxtaposition with the perception of the Highlander as pacified and loyal citizens which gradually developed in the period after the failure of the '45 rebellions, while the global economic downturn from the 1870s led to widespread distress, particularly acute in the western districts. Numerous parliamentary enquiries reported on the serious conditions in the Highlands, not least of which was the lack of medical provision and the inability of the parochial medical system to cope in the remote areas of the Highlands and Islands. The political and social environment of the late nineteenth and early twentieth centuries which increased knowledge of conditions in the Highlands, exacerbated by the need to ensure the efficient working of the National Insurance Act by the ability of the employed in the Highlands to obtain such services, and the availability and ability of doctors to provide cover under the Act, provided the immediate stimulus for the improvement of medical services in those remote areas

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<sup>90</sup> Mackenzie's scheme was not discussed by the Treasury but was not implemented. The reasons are discussed in Chapter 6.

<sup>91</sup> *Dewar Report*, p.34.

and believed by some writers to be a prime motive for the establishment of the Dewar Enquiry.<sup>92</sup> However, while the National Insurance Act of 1911 was most certainly a major catalyst for the Dewar Enquiry, the activity throughout the preceding years was crucial in establishing the scale of the problems in the Highlands.

The changing world order; the diminution of Britain as a world leader and the decline in the strength of the traditional liberal laissez-faire individualist ideology during the later nineteenth century, represented the wider context for the changes occurring at this time. The principle of self-help and the deserving poor, though still widely accepted, were under attack from the 1870s and diminished further by the Liberal welfare reforms during the period leading up to the Dewar Enquiry.

A residual fear of the escalation of localised unrest is also evident in this period:

...in view of the failure on the part of the Government to carry the Small Landholders (Scotland) Bill through Parliament and the urgent need of land legislation for the Highlands, will the Government consider the expediency of introducing a short Bill to meet the special requirements of the crofting counties and thus allay the unrest disclosed by the land seizures in Vatersay, and the more recent seizures in the island of Lewis, and threatened seizures in Harris.<sup>93</sup>

It is questionable whether the provision of medical services in the Highlands would have been judged as important enough for a separate enquiry. As Cameron has stated:

The importance of changing perceptions of the Highlands in the 1880s was that they were diverse and wide-ranging; this ensured that the Highland land problem, which seemed to parallel events in other parts of the United Kingdom, could not be ignored by the journalistic and political community.<sup>94</sup>

Political factors were of great significance given the contemporary climate. The individuals who formed the committee help to explain its success in producing an immensely authoritative and detailed report in such a short period of time. All members of the committee brought an immeasurable amalgamation of medical, public health and general expertise to the process, as well as a thorough, and in some cases, native knowledge of the Highlands. The inclusion of a number of individuals who were well known nationally and who were prominent in the Highlands – and therefore likely to be sympathetic to the area – must have inevitably smoothed the path of the

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<sup>92</sup> D. Hamilton, 'The Highlands and Islands Medical Service', in *Improving the Common Weal*; M. McCrae, *The National Health Service in Scotland: Origins and Ideals, 1900-1950*, p.1.

<sup>93</sup> *H.C. Debates*, 5 July 1909, Vol. 7, c801.

<sup>94</sup> E. Cameron, *Poverty, Protest and Politics*, p.248.

committee and prevented any perception of it having been imposed from Edinburgh. Neither could the Committee, however, be considered to have been set up to report traditional orthodox views. MacKenzie was one of the most vociferous of the radical Liberal medical influences in Scottish welfare and his deep-seated views on welfare provision were widely recognised. He was a leading advocate of the new philosophy which 'saw medicine not as a palliative nor a means for private gain, but as an instrument of social development, firmly rooted in the validity of human experience.'<sup>95</sup> His close friendship with the Webbs was indicative of their similar outlooks. Dewar's position on the board can be seen as a steadying influence to the more radical Liberal views of MacKenzie.

As well as having that combined knowledge and experience of medicine and the Highlands the Committee was also fortunate to have the efficient and effective administration of Murdoch Beaton, himself a native of the Highlands. The methodology he adopted was very successful in enabling them to gather information quickly, backed up with visits to a number of Highland locations, and produce a detailed extensive report in a relatively short time.

The appointment of Dewar as Chair, made during the Minority Liberal government, has been regarded as one of a series of non-Conservative public appointments at this time, designed 'to keep some semblance of civil service neutrality'.<sup>96</sup> The Conservatives attempted to reduce political bias in departments under their control by appointing non-Conservative chairmen.<sup>97</sup>

A considerable number of appointments have been made, and I think it is desirable that we should know the names of those appointed, their official designation, their salaries, their term of office, whether they have served before, and so on. We were informed by the late Secretary for Scotland that the greatest care would be taken to pick out the most impartial and best men of every sort and kind, and I merely wish to know who have been appointed up to the present time.<sup>98</sup>

The Marchioness believed that a factor in her appointment to the Dewar Committee stemmed from her husband accusing the Chancellor of the Exchequer, Lloyd George, of appointing an undue number of Liberals to administer the National Health

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<sup>95</sup> I. Levitt, 'Mackenzie, Sir (William) Leslie (1862–1935)', *Oxford Dictionary of National Biography*, Oxford, 2004; online edition, May 2006, [www.oxforddnb.com/view/article/55652](http://www.oxforddnb.com/view/article/55652). (Accessed 31 October 2007.)

<sup>96</sup> *HL Deb*, 15 May 1912, vol.11, c1069.

<sup>97</sup> I. Levitt, *Poverty and Welfare in Scotland, 1890-1948*, Edinburgh, 1988, pp.50-51.

<sup>98</sup> *HL Deb*, 15 May 1912, vol.11, c1069.

Insurance Act in Scotland, pointing out to the Commons that the Insurance Act would be of little use to crofters who worked for themselves. She suspected she had been invited to the Committee 'mainly in the hope of placating her husband.'<sup>99</sup> The concern regarding Liberal appointments to key positions can be seen as a Conservative backlash against the Liberal appointments mentioned earlier. She was a forceful personality and was regarded as having radical views. She cannot be seen as a quiescent Conservative voice on the Dewar Committee.

The inclusiveness of the enquiry can be queried; unlike the Crofters' Commission in the 1880s, an interpreter was not provided. The Census of 1881 recorded 87% of Gaelic speakers (over 200,00 people) residing in Highland counties; by 1911 that figure had fallen to 74%, representing over 150,000 people, still a significant proportion of the population. 139,000 of those native Gaelic speakers lived in the Highland counties of Ross and Cromarty, Inverness, Argyll and Sutherland, out of a total population of 274,000 inhabitants, just over half the population of those three counties.<sup>100</sup>

By omitting the services of an interpreter non-English-speaking Gaelic-speakers were excluded from presenting evidence to the Commission. Witnesses to the enquiry stated that the need for Gaelic-speaking doctors and nurses was mainly for the elderly, many of whom spoke no English, but was not confined to that age group, for example, the Third Battalion of the Cameron Highlanders, composed of young men from North and South Uist, Harris and Benbecula, was 'entirely Gaelic speaking'.<sup>101</sup> Witnesses stressed the need particularly for Gaelic-spoken nurses and debated the problem of sending local girls to the south for training which, by exposing them to a different lifestyle, would incur the risk that they would not return.

Of those who presented evidence, 'professional' witnesses, who had served on previous commissions and, government enquiries are evident. For example, one of the witnesses, John McLean, a crofter from the Coigach district of Inverness-shire, seventy years old and a parish councillor for twenty years, (described by *The*

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<sup>99</sup> *Working Partnership*, p.73. *Who's Who of British M.P.s*, Vol.11, 1886-1918, Sussex, 1978.

<sup>100</sup> Gaelic speakers by area of incidence 1881-2001: numbers and proportions in areas of different intensity, K. Mackinnon: SGRUD Research; [www.arts.ed.ac.uk/celtic/.../Gaelic\\_area\\_incidence\\_1881\\_2001.ppt](http://www.arts.ed.ac.uk/celtic/.../Gaelic_area_incidence_1881_2001.ppt), accessed Sept 2010; Flinn, *Scottish Population History*, p.306.

<sup>101</sup> *R.C. on the Militia and Volunteers, Minutes of Evidence*, Vol.11, 1904, Cd.2063, p.227.

*Scotsman* as a 'representative crofter') had given evidence to several commissions, including Napier.<sup>102</sup>

While other issues obviously influenced the decision to establish the enquiry it is clear that the sustained efforts of certain Members of Parliament, such as Cathcart Wason and McPherson, to raise awareness of conditions in the Highlands and Islands in Parliament and the press, was an additional and not inconsiderable factor in the establishment of the Committee. The *BMJ* reported:

Medical men in the Highlands and Islands of Scotland owe a debt of gratitude to the member for Orkney and Shetland – Mr Cathcart Wason – who, in his place in the House of Commons and at public meetings, has taken every opportunity to show the disabilities under which medical practice is carried on in the Highlands and Islands.

Throughout the enquiry it was clear that the Committee took a broad approach to their remit. Information on employment, lifestyle and environment were sought in addition to the scale and nature of medical services provided and how each service contributed to the health of the population and whether any coordination could be determined.<sup>103</sup> The focus was not solely on the National Insurance Act, a point some writers have over-emphasised, it was one of the many issues addressed and examined.<sup>104</sup>

The Dewar Enquiry led to the HIMS. Passed through Parliament with little dissent, it was virtually the last of the Liberal reforms, which had cumulatively resulted in pensions, free school meals and medical inspections, labour exchanges and the National Insurance Act. In comparison to the National Insurance Act, it affected a small number of people in a peripheral area of Scotland. It was smaller, shorter, and had less visible impact to the majority of the UK population than that of the major enquiries of the nineteenth and early twentieth centuries, such as Napier and the Poor Law Commission of 1909 but had long-term consequences in the direction taken throughout the twentieth century of state medical provision. It was a clear statement that the Highlands and Islands required special attention. In the long term it paved the way for further developments throughout the decades following the enquiry. Chapter Six will examine the establishment, structure and institutional framework and implementation of the HIMS, which was established on the recommendation of the

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<sup>102</sup> *Dewar Evidence*, Q.3611, p.96; *The Scotsman*, 22 August 1912, p.4.

<sup>103</sup> *Dewar Report*, Q.107, p.5.

<sup>104</sup> D. Hamilton, 'The Highlands and Islands Medical Service', in *Improving the Common Weal*; M. McCrae, *The National Health Service in Scotland: Origins and Ideals, 1900-1950*, p.1.

Dewar Committee, but which did not follow the structure recommended by Mackenzie.

## CHAPTER SIX

### THE EARLY ADMINISTRATION OF THE HIGHLANDS AND ISLANDS MEDICAL SERVICE

In 1909 the *British Medical Journal* reported:

The truth is, there is something altogether rotten in the present system of providing for medical and surgical attendance in certain ‘congested’ districts of the Highlands and islands of Scotland.<sup>1</sup>

That statement was in a letter by a doctor who had forty years’ experience of working in the ‘miserable conditions of medical relief in the Highlands’. As the previous chapter demonstrated, when the Dewar committee carried out their enquiry three years later, although more doctors were in positions in the Highlands, few significant improvements in salaries and conditions of work had been effected. Those improvements which did occur were positioned within virtually the same administrative structures which had been established over sixty years earlier, despite the creation of the Medical Relief Grant in 1848. Though the Grant aimed to encourage the employment of more doctors it did little to improve their working conditions and, when, in 1885, half the cost of trained sick nursing in poorhouses was allowed as a first charge against the grant, its potential for improving Highland medical services diminished.

The general recommendation of the Dewar Committee was unambiguous:

It is clear that having regard to the economic conditions prevailing in the Highlands and Islands, the extent to which the foregoing services are at present subsidised from Imperial funds is quite inadequate, and that as local resources are in many parishes already well-nigh, if not wholly, exhausted, any general amelioration of the existing medical service cannot be achieved without a further and more substantial subsidy.<sup>2</sup>

It recommended that an additional imperial grant should help develop the medical and nursing services and their administration and provide a ‘more satisfactory financial basis

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<sup>1</sup> *BMJ*, 27 Nov 1909, p.1577.

<sup>2</sup> *Report of the Highlands and Islands Medical Service Committee (Dewar Report)*, Vol. 1, Cd.6559, 1912. Part IX, General Recommendation, para 160. p.41.



for general medical practice'. The improvements were also intended to incorporate nursing and hospital provision and a specialist service.

The recommendations contained in the report were debated at length in Parliament and were unanimously accepted by the government. The Highlands and Islands (Medical Service) Grant Act was passed in August 1913, less than a year after the Dewar Committee presented its report to Parliament. The sums involved were relatively small; the charge on the state of the National Insurance Act in 1912 was £1.75 million, the Highlands and Islands Medical Service (HIMS) grant £42,000 per year.<sup>3</sup> (See wording of Act at Appendix 6.)

The remit of the Act was to provide for the administration of schemes prepared by an appointed Board to improve the medical and nursing service in the Highlands and Islands, funded by the new Exchequer grant. From its beginnings writers have been aware of the Highlands and Islands Medical Service, though none did more than note its establishment. In 1918 Day merely referred to the passing of the Act and listed the conclusions of the report.<sup>4</sup> He was, of course, writing very close to the start of the service when there was little to report. In 1958 Ferguson briefly raised the Service, with little detail and it was not till 1987 that Hamilton introduced the subject into modern historiography. Though it contained little detail it was important in setting out the background and development of the HIMS in a short six page article which covers the period of this research. While it provides a short description of the early years it relies heavily on the early annual reports of the HIMS. It has been widely cited by others and subsequently little detailed research or analysis has been carried out.<sup>5</sup> Collacott, in a thesis examining the development of general practice in the Scottish Islands from the 'earliest times' to the 1980s, has written most extensively on the HIMS and though the long period of the study allowed little space for detailed analysis he does cite some useful and rare consultation records from a practice in Scolpaig in North Uist which shows the percentages of patients seen by doctors in that practice under the various medical bodies

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<sup>3</sup> *Highlands and Islands Medical Service (HIMS) Grant Act, 1913*; T. Ferguson, *Scottish Social Welfare, 1864-1914*, Edinburgh, 1958.

<sup>4</sup> J.P. Day, *Public Administration in the Highlands and Islands of Scotland*, 1918, London, p.130-133.

<sup>5</sup> D Hamilton, 'The Highlands and Islands Medical Service', in G. McLachlan (Ed.), *Improving the Common Weal: Aspects of Scottish Health Services, 1900-1984*, pp.485-486, 1987.

in the Highlands. Official papers of the HIMS show only county figures which mask variations within localities. His thesis also provides a useful chronology of the development of medical services in the islands over a long period.<sup>6</sup> McCrae begins his book on the National Health Service in Scotland with a chapter on the HIMS. It has limitations in its analysis and is factually incorrect in several areas, including the initial administrative structures of the HIMS and in the level of progress made. Lacking effective primary research it documents general and unmitigated progress, which examination of the Treasury and Scottish Board of Health (SBH) files contradict.<sup>7</sup>

Only Dingwall and Jenkinson, almost uniquely in the available literature – while not dismissing the unique and innovative nature of the HIMS – acknowledge that the Service was ‘not altogether successful’. Jenkinson provides a more balanced viewpoint generally of the HIMS but does not discuss the Dewar Enquiry apart from attributing its establishment to the National Insurance Act.<sup>8</sup>

This chapter therefore relies heavily on primary sources, those secondary sources which do exist being limited to short descriptions of the Service. Within this narrow framework of existing publications this chapter, for the first time, examines in detail the establishment of the institutional framework of the Highlands and Islands Medical Service Board and its subsequent development till 1936. It does so chronologically over two chapters. This chapter, the first of the two, examines the debate within Parliament and the medical profession prior to the appointment of the Board and the early development of the Board, concentrating on the control and administration of the proposed Grant. This will include the response of the localities to a request for information; an early action of the Board. The Board requested suggestions on the level and type of improvements needed in medical and nursing and hospital provision and on specialised medical services. The returned schedules contain useful information on the level of improvements considered by the Highland population to be necessary, as opposed to the members of the Board and the Dewar Committee, restricted as they were

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<sup>6</sup> R. Collacott, Unpublished PhD thesis, A study of the development of general practice in the Scottish islands, Leicester University, 1982, p197. Practice information reported by the HIMS shows county information, within which there could be great variations.

<sup>7</sup> M. McCrae, *The National Health Service in Scotland*, East Linton, 2003.

<sup>8</sup> H. Dingwall, *A History of Scottish Medicine*, Edinburgh University Press, 2003; J. Jenkinson, *Scotland's Health, 1919-1948*, Oxford, 2002.

by financial considerations.<sup>9</sup> The Board produced detailed schemes based on a de-centralised administration structure. A delayed decision by the Treasury resolved to have a centralised structure and new detailed schemes had to be developed by the Board.

The second chapter (Chapter 7) examines the service from 1915, when the revised schemes were finally approved. The development of schemes were hindered by the First World War and the response of the Board to the financial restrictions caused by the war is examined.<sup>10</sup> Following the war a significant surplus had accumulated. However, the financial restrictions caused by post war inflation seriously reduced the value of the surplus which had accumulated and consequently the development of the schemes. Discontent was evident as doctors threatened to terminate their agreements with the Board. (An example of an agreement with the Board can be seen at Appendices 7a&b.)

The early difficulties continued well into the 1920s as the Treasury continued to restrict expenditure. In 1926 the Consultative Council of the SBH reported on the adequacy of services provided by the Fund and though they reported on progress in some areas, such as the employment of additional doctors, the report found it appropriate to ‘emphasise the need for State assistance towards a more comprehensive system of medical services than the Highlands and Islands at present possess’.<sup>11</sup> The Medical Service Grant was reviewed in 1929 and following the passage of the Highlands and Islands (Medical Service) Additional Grant Act 1929, additional funds were made available by means of an annual estimate, to be voted by Parliament. At that point the HIMS was transferred to the newly created Department of Health for Scotland (DHS), under the 1929 Local Government (Scotland) Act. The Act gave expanded County Councils greater resources and reduced some of the pressure of the rates.<sup>12</sup> From that point the HIMS was able to increase the implementation of the smaller schemes, the only substantial progress till then having been the Medical and Nursing Schemes. The historiography of the HIMS has provided a relatively standard whiggish reportage of the service. This chapter aims to deliver a more detailed and nuanced account of the early development. Throughout this and the

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<sup>9</sup> NRS, HH65/5, Returned Schedules of Highland Counties in Medical Service Board's area, 1914.

<sup>10</sup> NRS, HH65/6-7, Papers relating to the administration of the Fund, 1916-1920.

<sup>11</sup> Report on Services assisted from the Highlands and Islands (Medical Services) Fund, Scottish Board of Health Consultative Council on Highlands and Islands, T161/1304, 1926.

<sup>12</sup> TNA T161/1304/S2433/2, HIMS Fund, Administration of Grant, 1929.

following chapter the relationship of the SBH and the Treasury and the medical profession is examined and the achievements and shortcomings of the service are assessed.

### **6.1 The calculation of the HIMS Grant, 1912**

The Dewar Enquiry had recommended a sum of £42,000 for the new grant. A memorandum to the Chancellor of the Exchequer from the Committee contained details of how the estimated figure was reached. It reveals useful information on the existing state of medical provision in the Highlands, despite the fact that by the Committee's own admission, many of the estimates were 'largely speculative but the result of a good deal of discussion.'<sup>13</sup>

To estimate the proportion of the total grant required to supplement medical incomes, statements of gross and net incomes were requested from medical practitioners. Of 170 doctors practising in the HIMS area, 102 were invited to give evidence. Of them, 47 provided details of their income, indicating perhaps a degree of caution or mistrust on the part of the Highland medical profession, fearing they would jeopardise their claim to any available subsidies. Table 6.1 shows the collated income of the 47, almost all from single-practice areas:

**Table 6.1 Incomes of doctors practising in the Highlands, 1913**

3	had a net income of	<£100
13	"	£100 - £150
14	"	£150 - £200
11	"	£200 - £250
4	"	£250 - £300

**Source: NRS, HH65/5, Estimate of approximate amount needed to improve medical provision, 1912.**

Only two of the 47 were earning as much as £300, the minimum net income recommended in the Report.<sup>14</sup> The majority of doctors in the Highlands were existing therefore on salaries considerably less than that recommended by the Dewar committee.

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<sup>13</sup> NRS, HH65/74, Correspondence from L MacKenzie to Sir James Dodds, 13 January, 1913.

<sup>14</sup> NRS, HH65/5, Memorandum to the Chancellor of the Exchequer from Dewar Committee, 1912; *Dewar Report*, Section 169, p.42.

Those with the lowest salaries of less than £100 must have been reliant, to a certain extent, on substantial payments in kind, as it was unlikely that any substantial income from non-medical sources was available in those areas or that the doctor had spare time to allocate to alternative employment.<sup>15</sup>

To subsidise medical incomes it was necessary to distinguish between single and multiple practice areas. Single-practice areas had one doctor for a district; multiple-practice areas had several doctors in a district. Of the 170 doctors in the Highland area, 10 required no subvention, 100 were in single-practice and 60 in multiple-practice areas. Of the 47 known incomes the total shortfall of the suggested minimum net income of £300 was £5,834. It was estimated that the average supplement required to bring them up to £300 was £130. When taken as applicable to the 100 single-practice areas, the total grant required was £13,000. It was estimated also that 15 additional doctors were required for the Highlands and Islands, each for single-practice areas at a cost of £4,500.<sup>16</sup>

For multiple-practice areas, the object of the grant was to allow doctors in the most populous areas to attend the most distant patients of poorer classes at as moderate a fee as that charged to patients of the same class living near the doctor's residence. An average of £75 was estimated for this purpose, amounting to £4,500 for the 60 doctors in multiple-practice areas. The total medical subvention required was £22,000.

#### **Table 6.2 Total Medical Subvention Required**

100	S.P. areas at £130	£13,000
15 (new)	S.P. areas at £300	£ 4,500
60	M.P. areas at £ 75	<u>£ 4,500</u>
TOTAL		<u>£ 22,000</u>

**Source: NRS, HH65/5, Memorandum to Chancellor of the Exchequer, 1912**

The cost of improving and subsidising nursing services was also considered. It was estimated that 100 additional 'nursing units' were required. The term 'nursing unit' was not just new nurses needed but also included the improvement and supplement of existing

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<sup>15</sup> Payment in kind did exist in some areas as money was scarce in rural areas. Oral evidence of Dr. Sidney Peace, Kirkwall, Orkney. The extent to which this practice was prevalent in the Highlands and Islands is uncertain. A daughter and grand-daughter of two Orkney doctors states that there was little payment in kind, but that people were very generous, especially at Christmas.

<sup>16</sup> NRS, HH65/5, Estimate of approximate amount needed to improve medical provision, 1912.

schemes of nursing in, for example, housing, telephone, communication, transit and facilities for training, by contributions to the existing associations that already took charge of nursing in the Highlands and Islands. The total outlay for the above purposes was estimated at £10,000.<sup>17</sup> The Dewar Report had stressed the importance of an efficient domiciliary nursing service in improving the conditions of general practice, by relieving the work of the doctor, and in the ability of trained nurses to be based in remote districts and insular communities.<sup>18</sup>

Institutional improvements were also included. The cost of building, where a new hospital was required, furniture, maintenance, nurses' salary, assistants and overhead charges was considered to constitute a total outlay per annum of £3,750. Of this sum, an income of £750 from local sources was expected from small payments by patients, insured patients and from parish councils for their patients, leaving £3,000 to be paid from the Grant. To this was added £500 to subsidise existing hospitals. The total outlay therefore proposed for hospitals was £3,500.<sup>19</sup> The modest level of expenditure on hospital building and improvements reflects the unsophisticated standard of institutional provision and care in the Highlands. No consultant surgeons were employed throughout the Board's area for a considerable number of years. For example, Orkney's first consultant surgeon was not appointed until 1928. He was on call 24 hours a day, 7 days a week. Before his appointment surgical operations were rudimentary, often performed in the patients' homes.

In view of the inadequacy of medical and nursing attendance on confinements, revealed during the enquiry, the Board considered establishing a special grant should be made to provide help for the wives of uninsured crofters and those of similar circumstances, although it was considered 'undesirable to give the uninsured the same maternity benefit as the insured'. The principle of self-help was integral to discussions. The average annual number of births was 5177, of which 3000, or 57 per cent, were estimated to be outside the provisions of the National Insurance Act. To provide maternity benefit in their case at

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<sup>17</sup> NRS, HH65/5, Estimated cost of improved nursing provision, 1912.

<sup>18</sup> *Dewar Report*, Part V, Provision of Nurses, pp.20-22.

<sup>19</sup> NRS, HH65/5, Estimated cost of hospital building and expenditure, 1912.

20/- would cost £3000.<sup>20</sup> That scheme was not subsequently developed but indicates the aspiration for the Service to be as wide-ranging and effective as possible.

To improve ease of communications an expansion of the telephone system was envisaged. As the capital cost of such an extension was outwith the scope of the Report the payment of rental fees was suggested, costing £6 per instrument. The provision required for 100 doctors, 200 nurses and 25 hospitals was £2,000. The only further charge on the Grant was its administration which was estimated as £1500. The total therefore which was calculated as required to execute the recommendations of the Dewar Report was £42,000.

**Table 6.3 Estimated Amount Required for Dewar Recommendations**

	£
To provide adequate medical attendance	22,000
Nursing provision	10,000
Hospital provision	3,500
Special Maternity Grant	3,000
Payment of telephone rents	2,000
Administration costs	<u>1,500</u>
Total	<u>42,000</u>

**Source: NRS, HH65/5: Estimate of approximate amount needed to improve medical provision, 1912.**

The Dewar Committee did stress to the Treasury that the total grant requested was an approximation, based on incomplete and imperfect data as were available, supplemented by the local knowledge of some of the members of the Committee and the experience 'of others in their fields'.<sup>21</sup> It was later recognised that the sum required had been underestimated. The inadequacy of the Grant was a key factor in the sustained problems faced by the Board over the forthcoming years.

A further issue was the inclusion of the £10,000 already voted for doctors' travel under the National Insurance Act, which further reduced the potential for on-going development. The estimate presented by the Committee was accepted by the Treasury.

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<sup>20</sup> NRS, HH65/5, Estimated cost of improved maternity provision, 1912.

<sup>21</sup> NRS, HH65/5, Note with Memorandum to Chancellor of the Exchequer, 1912.

## 6.2 The structure of the proposed HIMS and early organisation

The Dewar Report did not specify the form a central authority should take, giving rise to much discussion from involved bodies such as the Local Government Board and the Insurance Commission. Prior to the appointment of the HIMS Board the future control and administration of the proposed Grant sparked heated debate between the Local Government Board for Scotland and the Scottish Insurance Commission. Both bodies, to a certain extent, already subsidised existing medical services, through the Poor Law Medical Service and the terms of the National Insurance Act. In the short intervening period between the publication of the Dewar Report and the passage of the Act, the Under-Secretary for Scotland, Sir James Dobbs, was lobbied by McVail, MacKenzie, and Sir George McCrae, the Vice-President of the Local Government Board for Scotland, all pressing their own interests in relation to the administration of the Fund.<sup>22</sup>

Dobbs, received a copy of the Dewar report early in January, prior to it being issued to MPs. He discussed it at some length with McCrae. Dobbs noted his thoughts on the administering authorities of the proposed Fund. Obviously heavily influenced by McCrae he came down heavily in support of a central administration predominantly fronted by the Local Government Board. The Under-Secretary for Scotland, stated confidentially 'it is essential that the Board (Local Government Board) should be the central authority'...and...'we should probably press that view on the Treasury at once'.<sup>23</sup> He noted 'no other authority can possibly be entrusted with the general administration of medical and nursing arrangements over a large section of the country.' Any other proposal would ensure the 'maximum friction with the minimum of efficiency'. Giving another authority such powers, he believed, would practically entail stripping the Local Government Board of its statutory powers under the general Public Health Acts. The only possible conclusion therefore, in his opinion, was that the main administrative functions of a central authority 'must be discharged by the Local Government Board'.<sup>24</sup>

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<sup>22</sup> The Secretary for Scotland Act was passed in 1889. The position became the Secretary for State for Scotland in the 1950s. D Torrance, *The Scottish Secretaries*, Edinburgh, 2006.

<sup>23</sup> NRS, HH65/74, Correspondence from Sir James Dodds, Under-Secretary for Scotland, 6 January 1912.

<sup>24</sup> NRS, HH65/74, Notes on the recommendations as to administering authorities, J Dobbs, 10 January 1913.



The main problems he saw were that while the recommendations of the Dewar Committee applied to almost the whole of the Highland population and covered practically the whole ground of Public Health administration, the powers of the Insurance Commission, on the other hand, did 'not extend beyond the class of insured persons and their dependants; in the Highlands a more restricted class than in other parts of the country'. He also pointed out that apart from those general considerations the Local Government Board was responsible in many areas for a wider spectrum of the population. Under Section 64 of the National Insurance Act, the Local Government Board was the body charged with the distribution of the capital grants for sanatoria, etc. The Government were required to provide an annual sum of money for half the estimated cost of treating tuberculosis in non-insured persons, as well as the dependents of insured persons. The allocation was to be distributed by the Local Government Board to local authorities which were to undertake to devise schemes for the general treatment of Tuberculosis in their areas.<sup>25</sup>

MacKenzie also favoured, with 'the majority of the Committee', the Local Government Board as the central authority but he foresaw opposition from the Insurance Commission. It was estimated that the amount contributed by, or in respect of insured persons, approximately one-seventh of the Highland population, would be £73,000 per annum, giving £17,500 for medical benefit alone. This, 'as McVail had casually remarked in Orkney' would induce the Insurance Commission to press for a more substantial 'look in' than mere committee association with the Local Government Board would imply. MacKenzie feared it would be 'difficult to prevent the Chancellor from taking a similar view'. However, given that they had no responsibility for any phase of Public Health, the Poor Law, Vaccination, Education or Lunacy, MacKenzie feared that to place the money unreservedly in the hands of the Insurance Commission would jeopardise those sections of public welfare.<sup>26</sup>

Mackenzie believed, on the other hand, that any attempt to make the Local Government Board the Central Authority would be met with strenuous opposition. He suggested that a possible solution was for each department to receive, direct from the Treasury, a

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<sup>25</sup> NRS, HH65/74, Notes re administering authorities, J Dobbs, 1913.

<sup>26</sup> NRS, HH65/74, Stated by McVail in Kirkwall during the enquiry.

proportion of the grant related to the requirements of the services for which they were responsible and be required to administer them along existing lines without raising any question of a predominant authority. He accepted however, that such a course of action would make any consolidation of services much more difficult.<sup>27</sup>

MacKenzie's concern was genuine and lay both in a desire to improve the conditions he had encountered in the Highlands and Islands and in the prospect of resources provided by the State to improve conditions there being used unsatisfactorily. He expressed a wish that whatever scheme was finally arranged would not simply end '...in an effort merely to increase the number of private practices or to subsidise individual practices as such. It seems an absurd waste of public money to let all the straggling services go on as at present when, with a little trouble, the whole of them might be so dovetailed as to lay the basis of an efficient medical service'.<sup>28</sup> The question of a new central authority he saw as an attempt at a compromise to prevent one department from dominating another in the administration of a grant which concerned them all. He viewed any new central body as a type of advisory council drawn from the departments concerned. McCrae and MacKenzie's lobbying was successful in preventing the Grant from being administered by the Insurance Commission, although neither was the Local Government Board given that responsibility.

### **6.3 The establishment of the HIMS Board and area of remit**

A new central administrative body, the Highlands and Islands Medical Service Board – the title MacKenzie had suggested such a body might be called in his appendix to the Dewar Report – was established for the purpose of the administration of the Grant.<sup>29</sup> The Board agreed to undertake the direct administration of the Fund, utilising existing local authorities and any other bodies likely to be of assistance.<sup>30</sup> Following recommendations and suggestions to the Treasury to this end, the Highlands and Islands (Medical Service) Grant Act, 1913 was passed on 12 July 1913, initially for a period of four years, till December 1917. (The Board was maintained as the administering body of the HIMS till

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<sup>27</sup> NRS, HH65/74, Letter from Dr Mackenzie to Sir James Dodds, 13 January 1913.

<sup>28</sup> NRS, HH65/74, Letter from Dr Mackenzie to Sir James Dodds, 13 January 1913.

<sup>29</sup> 'It is suggested that the Treasury representative should be chairman of a central authority which might be designated as "The Highlands' and Islands Medical Services Committee". *Dewar Report*, p.50.

<sup>30</sup> *Dewar Report*, p.50.

1919, when it was disbanded and the HIMS incorporated into the Scottish Board of Health (SBH).)

The Act provided the annual sum of £42,000, calculated by the Dewar Committee, to be called the Highlands and Islands (Medical Service) Grant, to be paid to a separate fund to be called the Highlands and Islands (Medical Service) Fund, 'for the purpose of improving Medical Service in the Highlands and Islands of Scotland, and for other purposes connected therewith.'<sup>31</sup> The Grant included the sum of £10,000 (approved prior to the publication of the Dewar report) connected with the attendance on insured persons in the Highlands and Islands, which was administered by the Insurance Commissioners (the corresponding grant for the Lowlands was £16,000). The disparity between the Highland and Lowlands Insurance payments was an increasing source of dissent between the doctors, the British Medical Association and the Board. The Chairman of the Insurance Commission recommended that the sum was retained on the Insurance estimates for that year due to the difficulties that would probably be experienced before the Highlands and Islands Medical Service Board would be in a position to assume administrative responsibility for the distribution of the Grant.<sup>32</sup> The new grant therefore was effectively £32,000, a point that is absent from all the existing historiography.<sup>33</sup> The estimates of £42,000 therefore immediately represented a shortfall.

The Act provided for the appointment of a Board to be the central administering body of the Fund. The Board was appointed on 11 September 1913, its administration to be in accordance with:

schemes prepared by the Board and approved by the Secretary for Scotland, with the consent of the Treasury, for the purpose of improving medical service, including nursing, in the Highlands and Islands of Scotland, and otherwise providing and improving means for the prevention, treatment and alleviation of illness and suffering therein.<sup>34</sup>

The Board required not less than five and not more than nine members, one of whom was required to be a woman. A Secretary to the Board, who was also the accounting officer,

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<sup>31</sup> *First Report of the Highlands and Islands Medical Service Board*, 1914, Cd.7977, p.18.

<sup>32</sup> NRS, HH65/8, Memorandum from Mr McQuibban on the question of additional Mileage Grants for insurance practitioners in England and the Lowlands of Scotland as affecting the position in the Highlands and Islands, 3 December 1919.

<sup>33</sup> *HC Debates*, 18 July 1913, Vol.55, cc.1657-68.

<sup>34</sup> *First Report, HIMS*, 1914, p.4.

was appointed by the Secretary of Scotland, with the approval of the Treasury. Board members did not receive a salary or fees. The Board comprised four members of the Dewar Committee and four others giving an element of continuity and direct knowledge of the issues to be faced, and also an element of objectivity and fresh insight. The four former Committee members were J.A. Dewar, the Chairman; J.C. McVail, from the National Insurance Commission for Scotland; W. Leslie MacKenzie, the Medical Member of the Local Government Board for Scotland and J.L. Robertson, the Chief Inspector under the Scottish Education Department. The newcomers were, Sir Donald MacAlister, President of the General Medical Council and Principal of the University of Glasgow; J. Macpherson, one of the paid Commissioners in Lunacy for Scotland and Lady Susan-Gordon Gilmour, the wife of Col. Robert Gordon and Honorary Secretary of the Scottish Branch of the Queen Victoria's Jubilee Institute for Nurses from 1911 to 1938.<sup>35</sup> Norman P. Walker, D.M. Treasurer of the Royal College of Physicians of Edinburgh was a later additional appointment in December 1913.<sup>36</sup> The Board comprised, as the Dewar Committee had, an impressive range of knowledge and expertise in conditions in the Highlands and Islands and also in medical matters. The Board encompassed all aspects of medical service provision in Scotland.

The passage of the Bill was not completely untroubled and the geographical areas to be included were the subject of heated debate during the passage of the Bill; 'whether the Highlands of Perthshire should be retained, and if so, whether other areas similar in character should be added.' The Marquis of Tullibardine was accused of looking after his own constituents and the dominance of certain views within Government was also questioned, 'It is extraordinary how this Radical Government is open to the influence of Conservatives'. Anti-landlord sentiments were implicit within the debate.

The debate continued throughout the latter part of July and early August, from its publication on 24 July 1913 and was described as 'an unseemly squabble'.<sup>37</sup> Objections to the inclusion of Highland Perthshire focused on other rural areas of Scotland, including

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<sup>35</sup> NRS, HH65/74, List of members of Medical Service Board; Lady Susan Lygon Gilmour (1870-1962) was created a Dame Commander of the Order of the British Empire in 1936 for services in connection with the Queen's Institute of District Nursing in Scotland. Typescript History of the Queen's Institute of District Nursing, nd.

<sup>36</sup> Announced by the *London Gazette*, 3 December 1913.

<sup>37</sup> *HC Debates*, 18, 21 July 1913, vol. 55.

Aberdeenshire, Morayshire and Fifeshire, which had similar conditions, and which required the government's attention. For example, the Parishes of Strathdon and Glenbuchat in Aberdeenshire, with a population of 1,354, had only 200 insured persons. 'The doctor covered wide areas in secluded valleys... frequently under snow for several months of the year, when the ordinary road traffic is conducted by means of sleighs'.<sup>38</sup> The Macalister Report, produced through the SBH in 1920 also made that point 'The conditions in the Highlands and Islands are so far special that for this region a separate Consultative Council for health services has been set up. But there are also in the Lowlands "Highland" areas, where the difficulties of medical practice are as great as those in the Highlands proper'.<sup>39</sup> Although there was sympathy for other areas there was no move to include them, confirming that the focus on the Highlands. There was also concern that if Highland Perthshire was not included in the HIMS area, then it would be included in the non-Highland mileage grant of £16,000, thus reducing the proportion available to the other non-Highland Scottish counties. The Bill had had its second reading on Thursday 24 July and passed through the Committee stage on 29 July, during which the Highland Perthshire districts of Balquhider, Callander, Comrie, Killin and Kirkmichael had been omitted from the schedule. Questions arose about the impact of the removal of those districts on the mileage grant but as the sum of £800 had been allocated to the Highland Perthshire it was considered that no reimbursement to the Lowlands was required.<sup>40</sup> Highland Perthshire was subsequently re-instated into the Bill and became part of the HIMS.<sup>41</sup>

The reasons for the reversal of the decision to remove Highland Perthshire is not documented but it is likely that the other rural areas were placated by the establishment of the Necessitous Districts (Lowlands) Grant, 'for necessitous districts in the Lowlands (which are really Highland localities outside the boundaries of the area technically constituting the Highlands)'.<sup>42</sup> The grant supported the establishment of general

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<sup>38</sup> *HC Debates*, 18, 21 July 1913, vol. 55.

<sup>39</sup> The Consultative Council on Medical and Allied Services, *Interim Report, A Scheme of Medical Service for Scotland*, Cmd.1039, p.9, 1920.

<sup>40</sup> *BMJ*, 9 August 1913, pp.276, 341.

<sup>41</sup> It comprised the counties of Argyll; Caithness; Inverness (excluding the Burgh of Inverness); Ross and Cromarty; Sutherland; Orkney and Shetland and the Highland district of Perth (as constituted in terms of the Local Government (Scotland) Act, 1889; *First Report, HIMS*, 1915, p.5; *Scotsman*, 24 July to 8 August 1913.

<sup>42</sup> *BMJ*, 19 July 1924, p.123.

practitioners, subsidised their income and the cost of transferring patients to hospital, doctors' means of travel, dispensaries in remote areas and 'difficulties of access and footpath miles.' The Necessitous Districts grant did not provide subsidised fees but otherwise echoed the HIMS Fund, '...which [was] not the only subsidy outside the Insurance Act to medical service in Scotland'.<sup>43</sup> The Grant does not appear in the historiography of the HIMS but its establishment reveals the strength of feeling about the requirement for central assistance for medical services in remote areas. It also reveals the determination to limit the new central grant to the Highlands. Highland Perthshire, having been included in the Dewar Enquiry, was in a strong position to lobby for re-instatement to the HIMS.

The area of remit, therefore, when finally agreed, was similar to that of the Dewar Committee. Inherent within it was the wider purpose of providing medical services to all, 'to give this grant the purpose of providing an adequate medical service in those districts, not only to those who are insured but to the whole of the population'. That underlying principle was core to the service but was queried in later years when the service was under pressure from post-war inflation and the classes eligible to participate was debated in Parliament.<sup>44</sup> The inadequacy of the existing medical provision had been clearly identified through previous enquiries and the landowners, many of whom had, or still funded, medical services within their estates, were those who their tenants would have looked to for the provision of those services. For example, within Shetland, Mr Traill, the Earl of Zetland and Mr Balfour Kinnear all contributed to medical clubs and the salary of a Jubilee nurse.<sup>45</sup> Not all landlords were so willing to support medical services on the islands. The 'overbearing attitude' of some landlords' representatives was reported.<sup>46</sup> The burden of the rates also fell to the Highland landlords, who were increasingly absent from the Highlands.<sup>47</sup> It was later noted that contributions to local medical and nursing services

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<sup>43</sup> *BMJ*, 7 July 1923, p.36; *BMJ*, 19 July 1924, p.123.

<sup>44</sup> NRS, HH65/7, General papers on Fund, Letter to Treasury, 1920.

<sup>45</sup> *Dewar Evidence*, Q.5914-16.

<sup>46</sup> *BMJ*, 3 Jan 1914, p.51. The area under discussion was Glenelg.

<sup>47</sup> *Dewar Evidence*, Q.11,017, p.231. Evidence of Provost Mackenzie in Stornoway.

fell as the Medical and Nursing Schemes were implemented, which added to the financial concerns of the Board.<sup>48</sup>

#### **6.4 Early preparations for the allocation of the Fund**

Once the locations included in the HIMS Service were confirmed a means by which the distribution of the grant was required. It was appreciated that the inadequacies of the medical service in the Highlands would not be removed simply by increasing the numbers of doctors, but that improvements in the co-ordination and administration of the services within the new scheme was required. The Dewar Committee had recommended that for the administration of the Fund both central and local authorities be constituted; the local authorities 'to retain the administrative interest of the parish' and to take into consideration the diverse conditions existing in the Highlands. It had been envisaged, and announced at meetings in the localities, that each local authority would establish a committee, to be known as Local Medical Service Committees.<sup>49</sup> Those committees would comprise the District Committee (i.e., the local authority for public health), which would form the nucleus, with additional representation from the Insurance Committee, county or district nursing associations, the British Medical Association and a member from one of the central departments involved. The Medical Officer of Health would also attend to provide advice and assistance where necessary.<sup>50</sup> The Under-Secretary for Scotland opposed discussion relating to the setting up of new local bodies due partly to the existing profusion of local bodies already in existence, the impracticalities of the remoteness of some districts and the resultant difficulty central members would have in attending meetings, but principally because of the difficulties involved in monitoring the consolidation of local services. The Board was therefore expected to administer the Grant utilising existing local authorities and any other bodies likely to be of assistance.<sup>51</sup> That decision was later, in part, reversed, when several of the schemes were de-centralised and transferred to County Councils or Public Health Boards.

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<sup>48</sup> TNA, T161/1304/S2433/1, 1920.

<sup>49</sup> *The Scotsman*, 16 August 1915, p.10.

<sup>50</sup> *Dewar Report*, p.40.

<sup>51</sup> M. McCrae begins his analysis of the HIMS by stating that the MacKenzie's scheme was accepted, making his analysis flawed from the start, *The NHS in Scotland*, p.14.

The Medical Service Fund Account was opened on 22 December, 1913. £41,800 was deposited in it with £200 kept for prospective payments. Initially, the Board considered several methods of making a first allocation on the Fund; on a population basis, on a valuation basis and on a basis combining population and valuation. Those methods were discarded, as variations in local circumstances and 'prevailing conditions affecting medical and nursing services' were such that such a system would be unlikely to secure fair treatment for all areas.<sup>52</sup> The allocation was therefore to be based on the actual needs of the districts. The scheme for a first allocation was formulated when the Board still envisaged the constitution of local committees for the administration of grants from the Fund. The Board did not at that point expect to be the sole body responsible for the administration of the Fund.<sup>53</sup>

Partly as a result of that assumption, the recommendations of the localities were sought. A Circular Letter was issued by the Board on 1 December 1913 to local bodies such as Parish councils, School Boards, Insurance Committees, local Medical Associations and other local bodies and persons interested in medical and nursing services and to all medical practitioners in the Highlands and Islands, asking for suggestions for the distribution of the Fund. Information was requested for an initial outlay of expenditure and annual charges thereafter. No indication of the money to be made available was given.<sup>54</sup> (See Appendix 4, Circular Letter sent by Board to localities.) Information was requested on the extent and adequacy of medical attendance provided under the various statutory public services, nursing services, hospital services and specialised medical services, including provision for the examination and treatment of eyes, ears and teeth; laboratory facilities, provision of surgical appliances and medical consultations.<sup>55</sup> The accompanying letter stressed that the proposed improvements to the medical services were not intended to relieve them of their existing obligations regarding medical services.<sup>56</sup> The Board were anxious, therefore, to emphasise at the outset that the Fund was to be used to help only those who had no alternative recourse to subsidised medical

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<sup>52</sup> NRS, HH65/5, Memorandum by Secretary of Board, 5 October 1914.

<sup>53</sup> NRS, HH65/5, Letter from McQuibban (Secretary) to Under-Secretary for Scotland, 11 November 1914.

<sup>54</sup> NRS, HH65/5, Issue of Circular Letter, 1 December 1913.

<sup>55</sup> *First Report, HMS*, 1915, pp.7-9.

<sup>56</sup> *First Report, HMS*, 1915, pp.7-9.



treatment and that existing sources of medical care should continue with no cessation of funding.

The delivery of the Circular Letter was greeted with great enthusiasm and optimism in most districts. Joint meetings of representatives from public bodies were arranged and public interest was high.<sup>57</sup> Replies were submitted by almost every parish in the area, as well as the larger bodies such as District Committees and County Councils. The completed schedules contained suggestions for the distribution of the Fund which greatly exceeded the amount available.

#### **6.4 Proposals received in response to Circular Letter from Highland Counties. Total Estimated Funding Required.**

County	Total Initial Outlay £	Total Annual Charge £
Shetland	11,310	7,328
Orkney	6,000	4,000
Sutherland	2,800	2,200
Caithness	1,600	2,705
R & Cromarty	32,865	8,309
Perth	600	1,000
Argyll	18,705	6,033
Inverness	<u>17,940</u>	<u>6,735</u>
	<u>91,820</u>	<u>38,310</u>

**Source: NRS, HH65/5, Papers relating to Allocation of Medical Services Fund.**

Table 6.4 shows that in total over £91,000 was requested for initial outlays and over £38,000 as annual charges. The responses did however indicate the basic level of medical and nursing care which existed in many areas and revealed the perceived need for improvement. The suggestions were very detailed and indicated a substantial need for improvements of almost all facets of medical and related services. As the proposals were submitted by varied groups no one body in any county could be accused of attempting to further its own interests.<sup>58</sup> In some areas however, the completion of the Schedule at the

<sup>57</sup> OIA, CO6/2/1, Minutes, Cross, Burness and Sanday, 1902-1930.

<sup>58</sup> NRS, HH65/5, Papers relating to replies received from Circular letter.

local level did not always reflect general opinion. Burray Parish Council viewed the schedule as 'the opinion of several important men'.<sup>59</sup>

The initial response of the Board was cautious, regarding many of the suggestions 'frequently of a very extravagant nature' and made 'with no regard to the share of the Fund that might reasonably be expected to fall to the various localities'.<sup>60</sup> In view of the enormity of the task, and to ensure objectivity, the proposals were summarised and submitted to the Local Government Board, the National Health Insurance Commission, the Scotch Education Department and the Board of Control for their observations and criticisms.

The Board decided to follow up the schedules with visits to the various localities to discuss with representatives of the local bodies the proposals submitted from each district.<sup>61</sup> In the course of the visits the local distribution and economic condition of the population and the geographical difficulties of the various districts were noted and the information obtained formed an important factor in the proposed allocation of the Fund. Some improvements occurred as a direct result of the Board's visits. For example, conditions on the outlying islands of Foula and St Kilda were such that it was decided to appoint fully trained nurses to live on the islands. The St Kilda nurse was appointed in May 1914 and the Foula nurse in December 1914.<sup>62</sup> (See Plate 11, man giving directions to Nurse Margaret Davidson, Foula). The visits to the localities were on the whole well attended and met with great enthusiasm. In addition to meeting doctors, other officials and individuals, they also made visits to hospitals, including the MacKinnon Memorial Hospital in Broadford, the John Martin Hospital in Uig and the Lewis Hospital, Stornoway. War broke out as the Board were nearing the end of their enquiries and only the last meetings in Highland Perthshire were poorly attended.<sup>63</sup>

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<sup>59</sup> OIA, CO6/16/49, Minutes, Burray Parish Council, January 1914.

<sup>60</sup> OIA, CO6/16/49, Minutes, Burray Parish Council, January 1914.

<sup>61</sup> OIA, CO6/16/49, Minutes, Burray Parish Council, January 1914. The Board were later criticised by the member for Sutherland (Mr Morton) for 'treat(ing) their work as a sort of holiday...borrowed a cruiser and went to a pleasant part of Scotland, namely Orkney and Zetland'. McKinnon Wood responded that the Board chose a fishery cruiser which was the cheapest form of travel, which was not a 'giddy holiday'. *HC Debates*, 15 July 1915, vol.73. The First Report of the Board also stated that the Fisheries Board placed one of their cruisers at the disposal of the Board for a few days, *First Report, HMS, Cd.7997*, 1915, p.11.

<sup>62</sup> Details of the locations visited and issues discussed appear in the First Report of the Board, *First Report, HMS*, 1915, pp.10-12.

<sup>63</sup> NRS, HH65/5, Visits of Board members to various districts, 1914; *First Report, HMS*, 1915, p.11.

The proposals submitted by Orkney and Shetland Counties illustrate the items contained within the proposals made by the Highland counties:

**Table 6.5 Suggested Requirements for the County of Shetland**

	Initial Outlay	Annual Charge
(1) Subsidy to Gilbert Bain Hospital.	500	
(2) 18 Cottage Hospitals @ £350 each.	6,300	-
Furnishing for " @ £120 each	2,160	-
(3) 21 nurses at £85 each.	-	1,785
(4) Mileage to doctors.		
(5) Subsidies to doctors for insured persons	-	900
(6) Two specialists or auxiliary doctors.	-	1,000
(7) Motor conveyances for doctors.	130	170
(8) 15 cycles for nurses.	120	
(9) Supplements for official income of doctors.	-	273
(10) Houses for doctors.	2,000	
(11) Motor ambulance.	600	
(12) Upkeep of 20 buildings @ £30 each	-	600
(13) Grant for TB Scheme.	No estimate	
(14) Dentist and Oculist.	No estimate	
(15) Telegraph or telephone services	No estimate	
	<u>£11,810</u>	<u>£4,728</u>

**Source: NRS, HH65/5, Synopsis of Replies to Board's Circular letter, pp.11-12, 1914.**

The range of improvements estimated to be required can be seen to be wide-ranging but reveal clearly the extent of improvements needed.

While the Board were collecting information in the Highlands during 1914, just prior to the announcement of war, and were preparing the initial schemes, it became evident that some immediate improvements were required in certain areas. To facilitate this, schemes of a temporary nature were approved by the Secretary for Scotland and the Treasury. The first temporary scheme permitted the Board to make mileage grants available to practitioners from the Fund equivalent to those allocated in previous years. The 1913 grant of £10,000 was paid to the various Insurance Committees under a scheme prepared by the Scottish Insurance Commissioners and approved by the Treasury. The Board were

unable, due to initial administrative limitations, to distribute equivalent grants at the beginning of 1914. A temporary scheme enabled doctors to claim a grant for mileage carried out in respect of insured patients, paid in three instalments. From 1915 subsidies were payable to doctors attending all eligible patients. Grants were made to practices to cover expenses such as medicines and the cost of travel to patients, regardless of distance. Those patients not covered by health insurance or the Poor Law paid a uniform fee of 5s for a first visit and 2s 6d for subsequent visits and £1 for midwifery. The grant attempted to ensure doctors' incomes did not fall below a minimum of £300, but there was little expectation in many areas that fees would be paid. A fee of 5s was a significant reduction for many, particularly those who lived at a distance from the doctor, but constituted a large proportion of a weekly income of 25s or less. 'There are very few crofters that can show a weekly income of 25s. a week.'<sup>64</sup>

The second temporary scheme was a Special Emergency Scheme, approved in February 1914, to enable the Board to help areas in urgent need, to meet cases of 'special and immediate difficulty'. Certain districts were unable to secure the services of a medical practitioner despite a subsidised salary from the Parish Council for the attendance of sick paupers, income from practice under the National Insurance Act and private practice plus donations from local landowners. Other areas, particularly smaller isolated islands, required a resident nurse urgently. Where districts urgently required the services of doctors or nurses the Board were permitted to meet the cost. The scheme permitted up to £2000 expenditure of a temporary nature to enable employment of doctors or nurses immediately. The nurse on Foula was one such appointment, as was the employment of a trained nurse, Nurse McLennan, with a salary of £70 a year, plus light and fuel, on St. Kilda in May 1914.<sup>65</sup> A house was provided by McCloud of McCloud and furniture by the Board. There was some concern about her ability to communicate with the mainland and questions about repairs to the wireless installation. The Board, in maintaining the nurse, however, did not consider they should meet any further costs.<sup>66</sup> When St Kilda was evacuated in 1930 a succession of nurses had been on the island since 1914. During 1914

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<sup>64</sup> *Dewar Evidence*, Q.22,130, p.447.

<sup>65</sup> *First Report, HMS*, 1915, pp.13-15; NRS, 65/11, Highlands and Islands Nursing services. Inverness-shire and Harris District, St Kilda; *The Scotsman*, 13 May 1914, p.10.

<sup>66</sup> *The Scotsman*, 22 July 1914, p.10.

the Board funded, or assisted the funding of four doctors in Harris, Latheron, Assynt and Kinloch Rannoch.<sup>67</sup> It also provided guarantees of salaries (partial funding to augment existing sources of funding) to assist the employment of doctors in Jura, Lochcarron, Rousay, North Ronaldsay and Northmavine and nurses in fifteen districts throughout the Board's area. Assistance was 'promised' for nursing services in Skye, South Uist and Croy, Petty and Ardersier, with others being considered.<sup>68</sup>

The third temporary scheme permitted the direct employment of doctors and nurses by the Board, to be placed where no medical provision was available, or to cover several areas where no permanent provision was available. The scheme for the employment of a doctor and a nurse was approved and but the scarcity of nurses and doctors prevented any appointments.<sup>69</sup>

The Schemes represent much of the progress made in the first year. The Board strongly emphasised, particularly in relation to the second scheme, that the grants were for the purpose of 'improving and increasing' medical service in the Highlands and Islands and not to relieve any part of the cost of those bearing it. Doctors were required to collect fees from non-insured and non-pauper patients on a scale which did not take into account the distance from the doctor and poor law and other local sources of revenue were to be sustained.<sup>70</sup> The requirement for the continuation and local contributory element to the medical services being provided in the Highlands was a recurring theme throughout the life of the Service. At no point was the grant intended to undermine individual responsibility, local people were required to 'have done their part'.<sup>71</sup>

It was suggested that in view of the financial stringencies caused by the War that the Board should attempt to recoup the money paid out for mileage in 1914.<sup>72</sup> For 1914 the Highlands and Islands Board adopted the Insurance Commissioners' Scheme of 1913 and through the agency of the Insurance Committee distributed £9,525, equivalent to the

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<sup>67</sup> An advertisement was placed for a post in North Harris, 'for permanent appointment, the payment guaranteed by the HIMS Board, which was required to bring the total remuneration 'from all sources', up to £300 a year. The post included a rent and rate free 'excellent modern house' and a small private practice. *The Scotsman*, 4 Jan 1915, p.1.

<sup>68</sup> *First Report, HIMS*, 1915, p.16.

<sup>69</sup> *First Report, HIMS*, 1915, p.14.

<sup>70</sup> *First Report, HIMS*, 1915, pp.13-14.

<sup>71</sup> *First Report, HIMS*, 1915, p.13.

<sup>72</sup> NRS, HH65/5, Letter from Treasury to Mr Jeffrey of the Insurance Commission, 1914.

amounts paid the previous year for mileage for attendance on insured persons in the Highlands and Islands.<sup>73</sup> As the Board had assumed the liability it was accepted that to get it back the Board would 'need a good case'.<sup>74</sup> A claim was made on the general ground that the payments 'would severely hamper the Board in giving effect to their Schemes'. Ultimately, under a Scheme framed by the Insurance Commissioners and approved by the Treasury, the amount of £9,525 was refunded to the Highlands and Islands Board.<sup>75</sup>

**Table 6.6 Amounts Paid to each Insurance Committee, 1913 & 1914**

	1913 from special Parliam. Grant	1914 from Board's Funds
County	£	£
Argyll	2,165	2,165
Caithness	390	390
Inverness	1,852	1,852
Ross & Cromarty	2,635	2,635
Sutherland	615	615
Perth	965	590
Orkney	383	383
Shetland	895	895
Seaman's National Insurance Society	100	
Total	10,000	9,525

**Source: NRS, HH65/8, Highlands and Islands Medical Service Fund, Supplementary Scheme A, 1913-1914.**

The war was to have far more serious repercussions on the newly founded Medical Service than was appreciated, both in terms of the availability of Funds during the war and the subsequent rise in post-war costs. Payment of the Medical Service Fund was suspended and as a result short-term ad hoc measures had to replace solid long-term planning for structural change. At the very inception of the Service the supply of doctors and nurses fell as the war enlisted medical personnel, 'tempted by the new

<sup>73</sup> NRS, HH65/8, Memorandum from Mr McQuibban on the question of additional Mileage Grants for insurance practitioners in England and the Lowlands of Scotland as affecting the position in the Highlands and Islands, 3 December, 1919.

<sup>74</sup> NRS, HH65/5, Allocation of the Medical Service Fund, General File, 1914.

<sup>75</sup> *Third Report, HIMS*, 1917, Cd.8519, p.12.

opportunities'.<sup>76</sup> The *British Medical Journal* also attributed the fall in supply of doctors to the increasing numbers of young men 'whose attention was directed to science' choosing alternative careers as engineers and in the chemical industries, and the poor conditions in the Highlands faced by doctors, including 'the faulty administration of the Parish Councils and the overbearing attitude assumed in some districts by the representatives of the landowners'.<sup>77</sup> The Board worked in cooperation with the Scottish Medical Emergency Committee to try and fill posts left vacant as a result of the war.<sup>78</sup>

At the end of 1914, as Table 6.7 shows, the limited activity of the Board resulted in a substantial balance; the income of the Fund for 1913-14 and 1914-15 was £84,820 18s, including interest, with expenditure just exceeding £11,000. The cost of salaries, wages and allowances and travelling and incidental expenses was £332 and £98 respectively.

**Table 6.7 Finances of the Board, 31 December 1914**

<b>INCOME</b>		
Grant-in-Aid, 1913-14		£42,000 0 0
“ 1914-15		42,000 0 0
Interest on Balance		805 3 0
Extra Receipts		15 15 0
Total		84,820 18 0
<b>EXPENDITURE</b>		
Medical Service		655 12 7
Nursing Service		475 10 6
Grants to Insurance Committees towards traveling expenses of practitioners		9,525 0 0
Balance at Credit of Fund at 31 <sup>st</sup> December 1914		73,164 18 0
Total		84,820 18 0

**Source: First report of the Highlands and Islands Medical Service Board, 1915, Cd.7977, p.17.**

Subsidies to doctors 'to cover travelling expenses and permit attendance at such fees as the patients can reasonably be expected to pay', included travelling expenses in respect of attendance on insured persons. Specialist medical services, assistance at operations,

<sup>76</sup> *BMJ*, 3 January 1914, p.51.

<sup>77</sup> *BMJ*, 3 January 1914, p.51.

<sup>78</sup> *The Scotsman*, 9 July 1915, p.8.

medical consultations and the extension of the telephone and telegraph services were intended 'at a later stage' when the cost involved had been ascertained.

The progress of the Medical Service in its first years therefore was limited in extent, partly due to the necessity to set up the administrative framework of the Service, which was then hindered due to onset of war. Notwithstanding the delays caused by the war, much of the delay in progress was caused by the decision not to have local administrative committees. The Secretary to the Board had presented to the Under-Secretary for Scotland a detailed proposal containing schemes for a first allocation of the Grant. Seeking the approval of the Secretary for Scotland with the consent of the Treasury, he stated,

the Board's proposals anticipate to a certain extent the approval of the Scheme for the constitution of local Committees for the administration of grants from the Fund...[submitted on 18 July 1914]...when the Committees are constituted they should be in a position to enter upon their work at once....<sup>79</sup>

That decision was outside the control of the Board, which had spent a considerable amount of time preparing detailed schemes based on allocations intended to be passed to those local bodies. As a result, MacKenzie's two-tier system was not adopted.<sup>80</sup> As noted by *The Scotsman*, the decision '[had] the advantage of simplicity and the disadvantage of destroying local interest.'<sup>81</sup>

The decision was based partly on the fear of local committees diverting funding to other projects and the difficulties of monitoring expenditure. For example, the Lewis District Committee in a letter to the Local Government Board, forwarded to the Board, expressed the hope that 'the Highlands and Islands Medical Service Board will endeavour to assist in the provision of the necessary accommodation for Tuberculosis'.<sup>82</sup> The Board recommended against the provision of specific services as it would lessen the funding available for general medical and nursing provision. By providing for an extension of the medical and nursing services the Board considered it would in effect improve the

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<sup>79</sup> NRS, HH65/5, Letter from Mr McQuibban to The Under Secretary for Scotland setting out the Board's proposals for the allocation of the Fund, 11 November 1914. Papers relating to the Allocation of the Medical Service Fund, 1913-15.

<sup>80</sup> NRS, HH65/5, General papers, 1914.

<sup>81</sup> *The Scotsman*, 16 August 1915, p.10.

<sup>82</sup> NRS, HH65/5, Letter from Lewis District Committee to Local Government Board, 8 October 1914.



domiciliary treatment of Tuberculosis. It feared the diversion of the Medical Service Fund by local committees to an alternative scheme, to the 'serious detriment' of the Board's general schemes.<sup>83</sup> The District Committee had considered that the funding provided by the local authority for TB would be provided out of the Medical Service Fund, which was expressly against the funding principles as the fund was not to be used to substitute local contributions. This example illustrates the potential local committees might have had for adapting the Board's schemes to suit local conditions.<sup>84</sup> The issue of local administration was re-visited after the war when inflation reduced the value of the Fund and other sources of funding were being sought.<sup>85</sup>

The decision not to have local committees required the preparation of new schemes, to be administered by the Board, 'utilising the assistance of existing local authorities and other bodies in any way that might be found to be desirable'.<sup>86</sup> The direct administration of the Board also required the employment of extra office staff and assistance in the general organisation and inspection.<sup>87</sup> The Board reported in their first report, 'Considerable difficulty has been experienced in adjusting schemes for the distribution of the Fund...the Schemes have not been finally approved and by the Secretary for Scotland and the Treasury, but it is hoped that they will be published shortly.'<sup>88</sup> Considerable time had been taken to develop the proposals, which had then been amended by the Treasury, prior to the decision not to have local administrative committees. That episode represented an inefficient use of both time and resources and was responsible for delays of almost two years before any progress was visible to the public and medical profession. Concerns were voiced in the *British Medical Journal* and Parliament; the enthusiasm surrounding the new service was thus subdued.

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<sup>83</sup> NRS, HH65/5, Letter from McQuibban to the Under-Secretary, 11 November 1914.

<sup>84</sup> NRS, HH65/5, Letter from Lewis District Committee to Local Government Board, 8 October 1914.

<sup>85</sup> NRS, HH65/7, Correspondence SBH and Treasury, 1920 regarding local administration of the Schemes.

<sup>86</sup> *Second Report, HIMS*, Cd.8246, 1916, p.4.

<sup>87</sup> TNA, 30414, HIMS, Organisation and Inspection, 1915-17, Letter from Mr McQuibban to Under-Secretary for Scotland, 18 August 2015.

<sup>88</sup> *First Report, HIMS*, 1915, Note on title page.

## CHAPTER SEVEN

### ‘A CHARTER FOR EMANCIPATION’?<sup>1</sup>:

#### THE DEVELOPMENT OF THE HIGHLANDS AND ISLANDS MEDICAL SERVICE 1915-1936

This chapter continues the examination of the continuing development of the HIMS from 1915, following the final approval of the amended schemes till 1936, when the Cathcart Committee reviewed health services in Scotland.

On 11 August 1915, eight ‘fresh’ detailed schemes were submitted to the Treasury. The lack of progress in the early years caused some degree of discontent at the delays, which were caused by the schemes having to be re-developed. Correspondence in the Scottish press expressed dissatisfaction ‘at the delay of the Board in coming to the assistance of the Highland people, and of their medical men’ and claimed the war ‘cannot be considered a cause for postponement of the Board’s scheme, but rather a reason for immediate action’. Another called for ‘an agitation for a prompt and thorough-going remedy... something more practical than pigeon-holed reports, ponderous blue books and costly tours of enquiry,’ and another ‘The conditions in the Highlands and Islands are quite exceptional, and the Board was appointed with full powers to deal with them. Yet, after repeated tours of minute enquiry, nothing is done to alleviate them.’<sup>2</sup>

Local appreciation and national awareness of the detailed efforts of the Dewar committee and the Board in seeking the views of the localities, was thus tempered by delays announcing the schemes, over which the Board had little control. The voting of the annual Grant in July 1915 also resulted in the Secretary for Scotland, McKinnon Wood, being questioned over unspent funds. For example, the member for Sutherland, Mr Morton, claimed ‘nothing of consequence [had] been done, except paying the salaries’. Morton blamed both the Secretary for Scotland and the Treasury, ‘for blocking the way’ [of the approval of the schemes] and demanded a full explanation. Other MPs clearly felt some disquiet also at the lack of progress, though expressed in a more reasoned manner. There was also concern from a number of

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<sup>1</sup> ‘A Charter for Emancipation’ was an optimistic term used by a number of doctors, including Dr Miller, former member of the Dewar Committee, in a critique of the HIMS in the *BMJ*, 11 Sept 1915, pp.404, 456.

<sup>2</sup> *The Scotsman*, 30 October 1914, p.8; 16 May 1914, p.13; 3 November 1914, p.3.

Scottish MPs about the scarcity of doctors and nurses in the Highlands, following the exodus to the war, many to the Royal Army Medical Corps. Assurances were provided by the Treasury that the schemes were in the process of being approved.

The war also caused restrictions on income and expenditure; the Grant for 1914-15 was not paid into the Fund. The funding was available if needed but the Treasury instructed that 'in view of the heavy demands on the Exchequer for war expenditure it was required that the issue of the Grant was to be restricted to sums required for necessary and immediate disbursement of funds.'<sup>3</sup> A further drawback was that no interest could accrue on the 1914-15 Grant. From the outset, therefore, the Board's actions were curtailed. The preparation of the rejected schemes, based on the existence of local administrative committees, wasted almost a year of alternative planning and development.

### **7.1 Approval of HIMS schemes 1915-1918**

The new schemes were finally approved on 15 August 1915, almost two years after the appointment of the Board. They comprised eight schemes which covered the principal areas identified by the Dewar Committee and documented in the Report:

Scheme A	Grants to Medical Practitioners
Scheme B	Grants to District Nursing Associations
Scheme C	Grants to Hospitals and for Ambulance Services
Scheme D	Grants towards the Provision or Improvement of Houses for Doctors and Nurses
Scheme E	Grants towards Specialised Services
Scheme F	Grants towards Extension of Telegraph and Telephone Facilities
Scheme G	Grants towards Employment of Doctors and Nurses by the Board
Scheme F	Special Emergency Scheme

Scheme A, Grants to Medical Practitioners provided grants to eligible doctors to improve their standard of living and set down the conditions under which grants would be made. (See Appendix 8, Public notice of arrangements between the Highlands and Islands Medical Service Board and medical practitioners.)

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<sup>3</sup> *First Report, HIMS*, 1914, p.12.

The development of an affordable, efficient medical service for the ‘crofting and cottar classes and their families’, with ‘fixed reasonable charges to persons of limited means, irrespective of their distance from the patient from the doctor’, was considered the ‘first and most pressing need’.<sup>4</sup> From the beginning therefore, the requirement of a contribution from those who could afford it was embedded firmly within the service. The HIMS was not a free service for all at the point of contact and was never envisaged as such.

To promote the provision of a ‘more effective general medical service’ the Board laid down conditions to the payment of grants under Scheme A. Doctors were required to

1. ‘visit systematically’ within their practices when asked to do so by anyone requiring medical treatment.
2. Within single practice areas continue to attend poor law, insured patients and any Public Health work requested
3. Attend midwifery cases
4. Attend ‘regular and systematic’ visits to designated areas on predetermined days
5. Have a car, cycle, boat or other means of travel for his practice
6. Attend to children in schools to treat illnesses identified under the medical inspection of school children
7. Keep a classified register, supplied by the Board and which was required to be open to inspection by the Board, detailing visits paid, the distance of the patient from his house and the fees collected

Doctors claims were categorised according to whether they were in single practice areas, in which case a supplement was considered to bring the total income up to a fixed agreed sum, or multiple practice areas, where a payment for additional work and any increase in travelling expenses was made for the treatment of patients at modified fees. It was appreciated that there might be difficulties allocating travelling costs to those incurred under the Poor Law and travel made under the Board but generally the view was taken that the provision of ‘travelling facilities for any public service’ would lead to efficiencies and enable more work to be carried out ‘for the community as a whole.’ It was also considered that a supply of qualified nurses in single practice areas would save doctors’ time and keep down the level of travelling expenses. On the question of fees the Board did not propose to intervene on a regular basis between doctor and patients. Doctors were to be requested to prepare a tariff of fees suited to

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<sup>4</sup> *Second Report, HIMS*, Cd.8246, 1916, p.5.

local circumstances to secure ‘maximum local contribution, which would include both those eligible under modified fees, the crofting and cottar classes and those non-insured who could afford to pay higher fees. Medicines provided by the doctor were to be charged separately unless covered by Insurance arrangements. Few additional doctors were perceived as being required once the travelling arrangements were in place, though it was appreciated that modification of that view might be necessary once the service was established. Other conditions aimed at improving the doctors’ working conditions included the provision of specialised medical services, including ‘eyes, ears and teeth, medical consultations and assistance at operations’. Provisions to enable holidays and professional development were also included to be funded by a grant to enable the employment of a locum. The Board completed their scheme with the proviso that a condition of the grant was the fitness of the doctor to discharge his duties and the effectiveness of the service provided by them. A common theme of previous years, also included in the Dewar report, had been the claim that some Highland doctors were occasionally considered to be unsatisfactory and prone to drunkenness. Many were past retiral age and therefore less effective; often not up to date with new medical developments. It was considered that it was difficult to get ‘good men to stay’.<sup>5</sup> Although that generalisation was applicable to a minority of doctors in the Highlands, that proviso most likely had its origins in those concerns. Finally, the Board announced its intentions to ensure that all local income would be maintained and that the grant should not in any form substitute or relieve existing local commitments.<sup>6</sup> Scheme A, therefore, addressed one of the key issues requiring attention identified by the Dewar enquiry, the conditions of work and income of practitioners in the Highlands.

Scheme B supported the development of an efficient, effective and better organised nursing service in the Highlands and also aimed to increase the numbers of qualified nurses. The Dewar enquiry had reported that the number of nurses in the Highlands was inadequate, often poorly trained and that nursing in the Highlands was largely reliant on the ‘voluntary effort of individual benefactors and philanthropic agencies’, some of which had been formed into nursing associations, but almost all of which lacked organisation. It also emphasised the important role of nurses in remote regions,

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<sup>5</sup> Sir Donald MacAlister in his evidence to the Dewar Enquiry reported three cases of drunkenness among doctors in the three years prior to the Enquiry. *Dewar evidence*, Q.23,068-9, p.476.

<sup>6</sup> *Second Report, HIMS*, 1916, pp.5-9.

particularly areas where a doctor was not available or where there was insufficient work for one, such as insular districts. The Board had already shown their commitment to that by placing nurses in Foula and St Kilda.<sup>7</sup> The second scheme therefore aimed to improve the organisation and effectiveness of the nursing service in the Highlands by providing grants to nursing associations and public bodies. Great emphasis was placed, as with all the Board's activities, on the retention of existing funding; the grants were to assist and not replace local effort. The main emphasis of the scheme was to improve and extend the organisation of nursing services, the current situation of which was acknowledged as being random, both in location and effectiveness. Implicitly the scheme continued to rely strongly on the 'benefactors and philanthropic agencies', many of whom were headed by the wives of landlords who provided funding or chaired the associations. For example, the Duchess of Atholl was President of the Perthshire Federation of District Nursing Associations.

The need for proper housing for nurses was fully appreciated but it was considered that as the numbers were rising that suitable rented accommodation or lodgings should be sought till any reorganisations required made it clear where a nurse would be most effectively located in each district. The supervision of a nurse by a practitioner was also a condition of the proposed grants, which in the most remote areas and islands, was not necessarily feasible. The nursing scheme therefore sought to build and expand on existing structures and make them more effective, within the existing funding infrastructure. The development of the HIMS nursing service is more fully addressed in Chapter 8.

Schemes A and B represented the principal means by which the Board intended to improve the nature, scale and quality of medical services in the Highlands. The remaining schemes, under which grants were to be made available for the building or extension of hospitals and ambulance services, the provision or improvement of houses for doctors and nurses, specialised services; to facilitate the extension of the telegraph and telephone network and to employ doctors and nurses directly by the Board, were all aspects of the service which would enhance and improve its core features. Integral to the conditions for eligibility of the schemes was the strict requirement for the continuation of existing local contributions. In addition, any

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<sup>7</sup> *Dewar Report*, pp.20-24.

structures or services which had been developed or were supported under the Poor Law or Public Health Acts were ineligible for funding.<sup>8</sup>

Immediately following the approval of the schemes copies of them were sent to all doctors working in the HIMS area, requesting responses within two weeks. The reaction both to the delay of the approval of the schemes and the announcement and timeframe of the terms of Scheme A to practitioners generated much dissent and debate. It suggested strongly that communications from the Board to the practitioners in advance of announcement of the scheme could have been more effective. There was also a perceived lack of recognition of the contribution to the war effort by Highland doctors.

No hint of these is contained in the schemes put before the doctors of the north and west of Scotland...; one is tempted to ask if, after all, there is not a perfect peace and an overflowing supply of medical men available in the Highlands, or, alternatively, if the Board has not succeeded in demonstrating that the Government departments exist and do their work in absolutely water-tight and non-communicating departments.<sup>9</sup>

The Scottish Poor Law Medical Officers' Association reported 'a considerable amount of friction' regarding the 'onerous' regulations required by doctors.<sup>10</sup> Concerns included the timing of the announcement, the additional work which the scheme would generate, the conditions under which grants would be awarded and the time provided for acceptance of the draft agreement.<sup>11</sup> The *British Medical Journal* reported, 'The Board got to work in November 1913, but beyond issuing its first annual report in June last [1915] gave no overt signs of life until, on August 16th, it launched upon the practitioners in the Highlands and Islands a series of documents of a voluminous and complicated character, and demanded much information and the acceptance of a draft agreement on or before August 31<sup>st</sup>'. Doctors objected strongly to the manner in which the schemes were disseminated, with a covering letter 'of the driest official sort' which did not explain clearly to them the changes in the mileage allowance for insured persons, which was to be included in the HIMS grant. Doctors expressed concern that though there was no intention to reduce the amount paid, there was no guarantee that it would be maintained or increased. Other areas of concern covered key parts of the proposed agreements:

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<sup>8</sup> *Second Report, HIMS*, pp.4-19.

<sup>9</sup> *BMJ*, 11 Sept 1915, p.409.

<sup>10</sup> *BMJ*, 5 Feb 1916, p.223.

<sup>11</sup> *Second Report, HIMS*, pp.4-19.

How...is a doctor to 'visit systematically and when asked to do so' all persons in need of medical attention...; how is he also to give personal attendance in midwifery cases, and to do these things while undertaking to make regular and systematic visits to certain localities on fixed days? How...is he to obtain and maintain his motor car or cycle, or motor boat? Is the capital expenditure to fall upon him, and when [they] are smashed or wrecked, is he to bear the cost of replacing it?<sup>12</sup>

Following the announcement and despite the complaints, it was also described in *The Scotsman* as 'a long step towards a centralised State Medical Service.'<sup>13</sup> Though it did not offer free treatment for all, it did represent a major step forward in the centralised provision of medical services to all, however hypothetical the reality was at that time. The concerns, however, challenged fundamental aspects of the proposed agreements and the Board were forced to acknowledge the unease of the doctors by arranging a series of meetings with them to discuss the detail of the schemes.<sup>14</sup> The meeting of the practitioners of Highland Perthshire in Logierait on 23 August to discuss the schemes and draft agreements provides an example. In a letter to *The Scotsman* they expressed serious reservations about the 'complicated and difficult to understand' one-sided scheme and almost all other aspects of it. Following meetings with representatives of the Board, however, the Highland Perthshire GPs were appeased enough to enter into agreements with the Board, including Dr MacKay, from Aberfeldy, who sent the letter to *The Scotsman*.<sup>15</sup> On September 13 the Inverness Division of the British Medical Association met with J.L. Robertson (former Dewar Committee and HIMS member) in Inverness, during which he allayed their fears enough for them to agree to the first stage of an agreement by completing the initial form, 'as a basis for further individual negotiation'.<sup>16</sup> (See example of agreement at Appendices 7a & 7b)

Due to the war and the financial restrictions placed on the Board, the introduction of modified fees in 1915 and 1916 was the Board's most pressing task. The slow progress since the Board's inception meant that a level of success was essential to prevent alienation of the practitioners. The organisation of the agreements and the scale of fees was complicated by the wide range of circumstances reported by the doctors in the schedules they were required to submit to the Board. Details requested

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<sup>12</sup> *BMJ*, 11 September 1915.

<sup>13</sup> *The Scotsman*, 16 August 1915, p.10.

<sup>14</sup> *Second Report, HIMS*, p.19.

<sup>15</sup> *The Scotsman*, 26 August 1915, p.9; *Second Report, HIMS*, 1916, p.49-50.

<sup>16</sup> *The Scotsman*, 13 September 1915, p.11.



included fees charged by them, how realistic they were in terms of affordability of the various classes and how their salaries might be affected by changes in fees charged. Information on public appointments held, income from private practices and travelling expenses were also requested. The Board were aware of the sensitivities of asking for personal information but reported that ‘in nearly every case [information being] freely supplied’. Dr Shearer, the doctor later employed by the Board to act as a locum, also spoke of the trust placed in the doctors, which was ‘so essential to the success of the scheme.’<sup>17</sup>

However, the Board found the task of setting equitable fees very difficult.<sup>18</sup> Practices in the Highlands and Islands included: those with little private income and salaries procured mainly from the ‘poor law, insurance and other public bodies’; those reliant on medical clubs; those with no clubs and where fees were adequate; those with a combination of club payments and fees per visit; insular and remote areas where income from all sources was inadequate and multiple-practice areas where work was shared by two or more doctors. Two main questions were identified; what could reasonably be charged to ‘persons of limited means’ and ‘what classes of persons should be eligible to participate’ in the scheme. After discussion it was decided that variable scales of fees were impractical and most probably unworkable. The difficulty of defining which districts were applicable for reduced fees and the inevitability of applying varying scales in areas where circumstances varied were too complicated. It was decided therefore to have a uniform scale of fees which would be applied to those eligible for them. After detailed discussions with the Scottish Office and the Treasury on the classes who should be eligible under the grant, it was agreed that the Scheme of modified fees should apply to:

- The families and dependents of insured persons
- Uninsured crofters and cottars, their families and dependents
- Others ‘in like circumstances’ for whom the payment of the doctor’s standard fee would be difficult

The fees were set at 5s for a first visit and 2s 6d for each subsequent visit for the same illness. For midwifery there was a fixed fee of £1. It was an essential part of the scheme that the fees charged should be the same regardless of the patient’s distance

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<sup>17</sup> A. Shearer, ‘The Highlands and Islands Medical Service’, in *The Transactions of the Medico-Chirurgical Society of Edinburgh*, 1937, p.9.

<sup>18</sup> *Second Report, HIMS*, pp.19-20.

from the doctor.<sup>19</sup> Following those key decisions the Board visited almost every doctor in the HIMS area, between September to the end of the year, during which their accounts were examined, the draft agreement adjusted and a provisional figure for the subsidy under the Scheme provided. The calculation of the subsidy was complicated and time consuming. It was determined, on an individual basis, by a number of factors. It included a sum, relating to that previously paid for travel under the National Insurance Act. It also estimated the likely level of attendance, based on what would have been paid had the scheme been in operation. It had to take into account a probable increase in visits, given the reduction in fees and the consequent increase in travelling expenses. For those doctors in the poorer areas the total income from all sources and the expenses of the practice were taken into account; in some areas a guaranteed income was required to ensure that a doctor was available. It was considered that in those areas an annual grant might be provided, once the level of assistance required was known. Those areas, mainly remote or island communities, were: Harris, Rassay and South Glenelg in Inverness-shire, Jura and Strachur in Argyllshire; Kinloch-Rannoch in Highland Perthshire; North Ronaldsay and Rousay in Orkney and Whalsay in Zetland. The terms offered under the guaranteed salaries were very generous, as an advert for Whalsay demonstrated. It guaranteed an income of £300, with free drugs, use of instruments, and complete surgery, with large modern residence, rent free, and all travelling expenses paid.<sup>20</sup> A more typical appointment was that for Saddell and Skipness Parish in Argyll, which offered a salary from the Parish Council (for attendance under the Poor Law) of £40, £6 6s as Public Vaccinator, £15 from the Local Medical Association, free rent and rates and a grant from the HIMS, estimated at £360 a year. That included attendance on 100 insured persons.<sup>21</sup>

Some doctors resisted the Board's attempts to involve them in the Scheme. Those in Coll, other parts of Argyll, Latheron in Caithness, Ardersier in Inverness and in the mainland parishes of Orkney; Hoy, Graemsay, Rousay and Egilshay had no arrangements with the Board.<sup>22</sup> However, despite the reservations expressed the majority of the c.170 doctors in the HIMS area did sign agreements with the Board. An example of the potential benefits to patients was provided, where the fees were

<sup>19</sup> TNA, 30414, HIMS, Estimate 1916-27; *Second Report, HIMS*, 1916, pp.20-21.

<sup>20</sup> *The Scotsman*, 1 October 1915; *Second Report, HIMS*, p.21-22.

<sup>21</sup> *The Scotsman*, 1 August 1916.

<sup>22</sup> *SBH, Report*, 1921, p.101.

reduced from £2 5s to 6s 6d, which included the doctor's fees for attendance and medicines.<sup>23</sup>

Some of the clauses in the draft agreements had to be revised following resistance from both the individual doctors and the BMA. It was accepted that 'regular and systematic visits' could not be enforced in all areas and that it was not feasible for all doctors to buy a car or motor-cycle. In such cases the requirement to attend when needed and the hiring of a car or other means of conveyance were accepted by the Board. When the majority of agreements were agreed the Board advertised in the localities, to let the communities in those areas which doctors had arrangements with the Board to provide modified fees. (See Appendix 8, Public Notice Of Arrangements Between The Highlands And Islands Medical Service Board And Medical Practitioners.)<sup>24</sup>

The lack of clarity and transparency inherent in the individual arrangements with practitioners also led to dissent. The promise of a £300 minimum income to doctors was refuted in a letter to the BMA. It was pointed out that if the doctor was unable to secure his fees the Board did not provide compensation, that is, it did not make up the doctor's income to £300 'free of all working expenses' (including charges for medicines). 'There is no check on patients who call the doctor long distances for trifling ailments and no extra fee for night visits', which the BMA later called for.<sup>25</sup> There were comparisons with the right for parity with English superannuation and calls for the grant to be increased. Another point of friction was that Army and Navy doctors received at least a £1 a day.<sup>26</sup> The early progress of the main Scheme, was not smooth and raised many issues which, in the light of increasing financial restrictions, were difficult to resolve.

Under Scheme 2, Nursing Services, the Board continued with the temporary Special Emergency Scheme, established in 1914. The main problem was the lack of nurses due to the high numbers signing up for war service. Nurses continued to be employed in St Kilda, Bernera, Foula and Fair Isle. The employment of a doctor in the Skerries, removed the need for a nurse under the Emergency Scheme.<sup>27</sup>

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<sup>23</sup> *Second Report, HIMS*, 1916, p.23.

<sup>24</sup> *Second Report, HIMS*, 1916, pp.24-25.

<sup>25</sup> HH65/7, Correspondence with BMA, 9 July 1918.

<sup>26</sup> *BMJ*, Oct 1915, p.552.

<sup>27</sup> *Second Report, HIMS*, 1916, p.26.

The first phase of the implementation of Scheme A was important in engaging the doctors with the aims of the HIMS. Restrictions caused by the war meant that the main expenditure was on Scheme A. Capital Expenditure remained largely on paper for a number of years and during the war years actual allocations were primarily on annual expenditure based on the amounts likely to be required to meet, firstly, subsidies to doctors and the provision of salaries for any additional doctors required; secondly, contributions towards an efficient nursing service; thirdly, annual grants to central hospitals and finally, contributions towards the upkeep of an ambulance service. By the end of 1916 expenditure under Scheme A was £20,000 . The estimated requirement for the next year was £28,000, which it was recognised would make the financing of the other schemes very difficult. The proportion of travel carried out under arrangement with the Board was 43.3%, with 23.3% for the attendance of insured persons. The remainder was to fee-paying patients. That average of course, concealed instances, particularly in the single-practice areas, where the proportion of travel would have been considerably higher under the Board's arrangements. The estimate for Scheme B, the nursing scheme, of £9,050 was considered to be 'not on the generous side'.<sup>28</sup> The Fund, from the earliest days, when the level of development was limited, can be seen to be under pressure at the same time that the grants from the Board were becoming an essential part of the medical service in some of the poorer areas.

The Board was under constant pressure from the Treasury to keep expenditure down. A balance of £98,540 at the end of 1915 led to a suggestion, in an internal Treasury letter, to reduce the budget for inspection of the doctors for 1916-17. 'I suppose it is out of the question to carry legislation to reduce the grant for 1916-17.'<sup>29</sup> The extra work involved in the direct administration of the schemes had led the Board to request help in the organisation and inspection of doctors, in the form of an external medical officer, Dr Cruikshank. The response on 3 January 1916, revealed the attitudes of those in the Treasury, who clearly had little or no understanding of the particular circumstances in the Highlands and Islands.

I don't think it can be stopped altogether, or we shall be in a position of paying the grants to the doctors without getting the delivery of the goods. You might suggest to McQuibban...that £100 for organisation

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<sup>28</sup> HH65/6 Allocation of Fund, General file, 1916.

<sup>29</sup> TNA, 30414, Correspondence re Organisation and Inspection, 30 December 1916.

and inspection will be ample. They won't like the idea of using LGB or Insurance Committee inspectors, medical or otherwise. I believe that the Board was begotten solely at the jealousy of those two departments of each other, but there is no excuse for employing outsiders to organise and inspect, when the main scheme is in working order, as it will be by 31 March next. Nor would I pay any more [to Cruikshank] but in exceptional and I think, unlikely contingencies...

So the Fund does not die with the Board, and legislation to reduce the grant would be highly contentious just now. The annual charges on the fund are about £40,000 but some of the schemes have been postponed for the War. The best chance of working better terms with the profession and so reducing the grant will be after the War: but before this can be done the Board must either cease to exist or be differently constituted. At present doctors are at a premium and their professional heads are distinctly swollen.<sup>30</sup>

The Board, therefore, was clearly successful in standing up to the Treasury to ensure it received all funding due to it and seeking additional funding when it considered it was required, but what this also reveals is that the HIMS represented an expenditure that the Treasury sought to reduce when possible and that the conditions existing in the Highlands were not fully understood. The Board were offered £100 for organisation and inspection. The matter was raised by McQuibban with the Under Secretary for Scotland stating that although arrangements with the doctors was nearly completed the arrangements were on an experimental basis, needing close inspection and supervision during 1916-17 'if the safeguard of public funds [was] to be properly safeguarded.'<sup>31</sup> The sums involved were small but this illustrates the close control of the fund by the Treasury and even the lack of commitment to it in the long-term.

For the remainder of the war the scheme of modified fees continued, with all other schemes virtually in abeyance. Under the HIMS Grant Act the Board was scheduled to end in December 1917, but as so little progress had been made during the war the Board was continued till 1919, at which point the HIMS was absorbed into the newly established Scottish Board of Health (SBH). The shortage of doctors and nurses placed increasing pressure on the modified fees scheme. During the two years of operation, examination of the records kept by the doctors had shown that the reduced fees were not required in certain areas by all those eligible for them whereas in other areas incomes were so low, affording 'such a bare existence' that payment of the

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<sup>30</sup> TNA, 30414, Correspondence re Organisation and Inspection, 3 January 1916.

<sup>31</sup> TNA, 30414, Correspondence re Organisation and Inspection, 3-17 January 1917.

modified fees were not feasible. An adjustment of the fees, though not implemented, was considered to exclude the 'better-off classes'.

The increase in travel

costs during the early years placed an increasing strain on the practitioners and the Board concluded that the grant should be fixed to cover actual travel carried out for work under the Board for modified fees and insured persons. That was intended to replace the grant paid, which was equivalent to the loss incurred by doctors while working under the scheme and charging reduced fees.<sup>32</sup> The war was not considered the best time to make a permanent change to the scheme and a temporary Emergency Scheme was established to enable increases in the mileage allowance. The rate of 6d a mile was increased to 9p a mile by car, motor-cycle, horse and trap or boat and 7d a mile for travel by train, cycle or on foot. The scheme also covered the cost to doctors of non-payment of fees under the Board's work.<sup>33</sup>

The Board, by the end of 1917, had arrangements with 141 practices, employing 149 doctors, see Table 7.1, some of which required more than one doctor. The cost to the Scheme was £21,300.<sup>34</sup> The numbers of doctors had remained reasonably steady since the start of the Service.

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<sup>32</sup> *Fourth Report, HIMS*, 1918, p.8.

<sup>33</sup> The amendments were made under the Supplementary Scheme A, War Conditions, 1917. *Fourth Report, HIMS*, 1918, p.9.

<sup>34</sup> *Fourth Report, HIMS*, 1918, p.10.

**Table 7.1 Numbers of doctors with arrangements with the HIMS Board to give attendance at modified fees in 1919**

Argyll		38
	Ardnamurchan	5
	Cowal	8
	Islay	4
	Kintyre	7
	Lorn	6
	Mid-Argyll	4
	Mull	4
Caithness		9
Inverness		34
	Aird	7
	Badenoch	5
	Inverness	5
	Lochaber	7
	Skye	5
	Harris	1
	N Uist	1
	S Uist	3
R & C		27
	Black Isle	7
	Easter Ross	7
	Lewis	4
	Mid-Ross	4
	South-Western	2
	Western	3
Sutherland		9
Orkney		7
Shetland		11
H. Perthshire		14
<b>Total</b>		<b>149</b>

**Compiled from Fifth report, HIMS Board, 1919, pp.24-36.**

By 1918 the impact of sparse funding and post war inflation which had reduced the value of the Fund caused tensions to increase within the Highland practitioners.

...feels like a great deal of the dissatisfaction on the part of the Doctors in regard to their relations with the Board is due to the fact that the Board is now considering the subsidies as in effect travelling grants

instead of as being monthly payments for the increase of work entailed by their introduction into their Scheme.<sup>35</sup>

During the war years the BMA had become increasingly concerned about the conditions under which doctors worked in the North, including the level of their incomes. The concerns were centred on perceived inequitable treatment for Lowland and Highland practitioners. The separate payments for attendance on insured payments was always contentious and once the scheme of modified fees was in general operation by the beginning of 1916, the separate payment for mileage was removed. It was an issue which remained a continuing source of tension for the doctors over the next years as inequities arose between the HMS doctors and those outside its remit. A 42 per cent increase in Insurance mileage grants was voted by Parliament for England & Wales and the Lowlands in 1917, leading to claims for corresponding grants for doctors in the Highlands, where distribution was made on the basis of a pro rata addition to existing Insurance Mileage grants. In 1918 also, additional Exchequer grants were made available to Insurance practitioners for 'increased practice expenses', which were not made available to the Highlands practitioners. The BMA were also concerned about the method by which the scheme of modified fees operated, providing, in the view of the BMA, reduced fees for many in the Highlands who did not require them, thereby reducing doctors' salaries.

In 1918 the BMA established a sub-committee on the Highlands, 'to consider and deal with all questions affecting practice in the Highlands and Islands'. Alerted by increasing complaints from doctors working under the Board, it carried out a survey of doctors' incomes and in a letter to the Board in July 1918, the Sub-Committee stated that it had considered the proposals of the Board for remuneration and found that they were 'entirely inadequate.. that the conditions of service proposed [were] unsatisfactory and not acceptable to practitioners serving under the Board'.

They made a number of suggestions including: that multiple-practice areas should be paid as a first charge on the Fund, similar to payments in the Lowlands; that remuneration for mileage should be on the same scale and conditions as those in the Lowlands; that some persons paid modified fees who could afford to pay more; that the present scale of fees should be continued; that the travel subsidy should be

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<sup>35</sup> NRS, HH65/6, Letter from BMA to SBH, 17 April 1919.



abolished and payment made on a capitation basis, based on calculating the loss to practitioners for attendance at modified fees or be paid for each mile travelled at a reasonable rate; that a uniform fee of £2 2s be set; that minor operations should have a fee set according to the circumstances of the patient; that night work should be paid at double the normal rate between 7pm and 7am and that doctors in single practice areas should be paid a minimum guaranteed net income of £500. Those demands would have placed a heavy burden on the Fund.

The Sub-Committee comprised five members of the BMA Scottish Committee and seven Highland practitioners. It was considered that there might be less objection to the Sub-Committee if it did not have Highland-based doctors on it, who would not have the authority to speak for all doctors in their areas. The Board were well aware that the findings of the Sub-Committee would not be ‘marked by a very strict impartiality’ but were concerned about the potential for the Sub-Committee to be supported ‘outright’ by the BMA, with the possibility of friction between the BMA and the Board. One of the main issues with the BMA demands was that as the Board negotiated individually with each doctor, any discussion on set requirements for all was potentially difficult.<sup>36</sup>

The Board considered the comments and suggestions of the Sub-Committee and robustly refuted the majority of them, including the charge that ‘remuneration was entirely inadequate’, which they claimed contradicted the facts collected by Dr Cruikshank and the Secretary on visits and inspections to many of the doctors. It also did not propose to pay mileage to any doctor under agreement with the Board and said that as it paid grants to cover loss of fees it was immaterial whether some benefitted who did not need it. It considered that a complication of that type was undesirable and stated that it would in fact have the effect of reducing the Board’s grants to doctors since the loss of fees would be lessened. It maintained that in some single practice areas the salary was £500 and in some it was less, and in some areas, such as Whalsay and North Ronaldsay the work load was light. The Board irately asserted that if the determining factor had been income then doctors would have been in a difficult position as the Board would have had to enquire into the income of all ‘doubtful

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<sup>36</sup> NRS, HH65/6, Minute of Secretary, 9 July 1919.

cases'. When income was provided in kind and not in money the difficulty would have been 'well-nigh insurmountable as well as the cause of unpleasantness'.<sup>37</sup>

The Board contemplated writing to all practitioners but did not want to appear hostile to the BMA. They instead invited a small group of the Sub-Committee to discuss the issues with them. Strong views about the interference of the BMA were expressed. Lord Forteviot had warned against allowing the Sub-Committee to 'manage [their] affairs' and Lady Susan Gilmour considered the statements of the Sub-Committee 'preposterous' and which would have 'swallowed up the £42,000 and more'.

McPherson believed, with others, that the Sub-Committee had failed to understand the policy of the Board, some of which was based on the policy of asking for as much as possible in the hope of obtaining for the doctors 'more than they get at present'.<sup>38</sup>

The meeting of the Board with the Sub-Committee on 28 September 1918 took the form of a meeting with an 'interested party', not as a meeting with the representatives of doctors under agreement with the Board. The discussions during the meeting, focused mainly on who should be eligible for modified fees. It emphasised the differences in the perception of the two bodies. The BMA looked to protect the doctors' interests, while the HIMS were concerned to protect the interests also of the poorer population, 'the central purpose of the HIMS Fund is to provide relief for the poorer classes of the community in the matter of medical attention.' The description of the HIMS was not strictly accurate as they were equally concerned to improve the conditions of the doctors. They were determined however, that any concessions to the Sub-Committee did not result in the doctors having discretion over those eligible for the scheme as they could not then justify their administration under the Act. On the suggestion that there should be a body to arbitrate in disputes the Board were firm in the position that they were 'not entitled or prepared to delegate their administration to any other body'.<sup>39</sup> Following the acrimonious meeting, during which neither side compromised on their positions, the Sub-Committee continued to express concerns about the disparity with doctors in the Lowlands. Comparisons with the Lowlands, they maintained, was not accurate, that England and the Lowlands distribution was on a capitation basis, in the Highlands it was on the amount of travelling done, therefore the amount paid could vary yearly according to the work done. Appendix 9, Statement

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<sup>37</sup> NRS, HH65/6, Draft letter from BMA to SBH, 17 July 1919.

<sup>38</sup> NRS, HH65/6, Minute, 9 July 1918.

<sup>39</sup> NRS, HH65/6, Notes by Secretary on meeting with BMA, 28 September 1918.

Showing the Amount and Distribution of the Total Work in 1917 of Practitioners for 114 Practices Working Under Arrangements with the Board, and the Like Information For 116 Practices in 1918, details the travel and visits carried out by practitioners during those years.

In 1918 and 1919 the level of travel involved was considered exceptional due to the influenza epidemic during the end of 1918 and the beginning of 1919.<sup>40</sup> The Treasury insisted that all extra travel costs had to be met from the unexpended balance of the Fund.

One of the last acts of the Board before the Service was incorporated into the Scottish Board of Health was to consider raising the fees to patients.<sup>41</sup> The matter was not progressed until later years but the intention to do so had its origins in the difficult period following the war, when the HIMS was under assault from both doctors and the BMA.

## **7.2 Transfer of HIMS to Scottish Board of Health 1919-1929**

Following the war it took some time for doctors and nurses to return to work in the Highlands and the financial problems of the Board continued, as post war inflation reduced the value of the balance which had developed. Doctors reported that increasingly they were finding it hard to collect fees, 'cannot even collect 2/6 fee per visit just now'. The point was forcefully made that as the Board was contemplating increasing the modified fees, doctors were predicting having very serious difficulties. The modified fees had greatly increased the number of calls received and it was feared that any increase would have the effect of 'reducing doctors' work amongst a class ...who should get as much attention as possible'. The increase in travel and visits is illustrated in Appendix 9.<sup>42</sup>

As a reaction to wartime inflation the minimum incomes for doctors recommended by the Board rose from £300 in 1913 to £360 in 1917. A minimum salary of £400 was aimed for in 1919. The response of the BMA was that doctors in isolated practices lived and worked in conditions in which even £500 would be barely enough to attract 'good men'. It was a salary which did not compare favourably to other areas of

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<sup>40</sup> NRS, HH65/6, Allocation of Fund, General file, 1919.

<sup>41</sup> NRS, HH65, Allocation of Fund, General file, 1919.

<sup>42</sup> NRS, HH665/6, Allocation of Fund, General file, 1919.

Scotland and which it was considered would only attract those doctors who were prepared to make a financial sacrifice. 12 posts were vacant in 1919 and difficulties were experienced in filling them, despite repeated advertisements. The cost of employing a locum, which required a fee, lodgings and car and driver could be as high as £55. In 1919 it was estimated that as many as 50 practices, or one third of the doctors in the Highlands, earned up to or less than a net income of £350 a year. To give all doctors a salary of £500 was estimated to cost £11,500, which the BMA stated was the equivalent of the Necessitous Districts Grants for insurance practitioners in the Lowlands, a consistent bone of contention between the BMA and the HMS.<sup>43</sup>

By 1919 all eight schemes were approved by the Secretary for Scotland and the Treasury, though all but the medical and nursing schemes were still on paper only. The administration of the service was then taken over by the Scottish Health Board (SBH). The Special Emergency Scheme was also still in place. In 1919 also, a locum, Dr Shearer, was employed directly by the Board, which enabled doctors to have a holiday or take a course in the lowlands. That was an important appointment, the first time many doctors were able to leave their practices.

By 1919 the balance of the Fund had grown to over £159,000, which was required for capital expenditure on houses, hospitals and ambulance services.

**Table 7.2 Balance of Fund at 31 Dec 1916-19**

1916	£98, 540
1917	75,000
1918	137,189
1919	159,460

**NRS, HH65/6, Allocation of Fund, General file, 1916-19.**

The incorporation of the HMS into the SBH altered the administration of the Fund, which from then on was run by officials in Edinburgh, with McQuibban still employed as Secretary, providing administrative continuity.

With the Board no longer the overseeing body the Treasury investigated the proposals of the SBH in which ‘the local administration of grants from the Fund in aid of

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<sup>43</sup> HH65/6, Allocation of Fund, General file, 1919.

nursing and certain other services may be assumed by local authorities'. The County or Town Councils were to be the bodies responsible, except in Highland Perthshire, Skye and the Outer Isles, where the District Committees (the local Authorities under the Public Health (Scotland) Act 1897).<sup>44</sup> This represented a major shift in policy, the centralisation of the service was one of the major decisions taken at the outset of the Service. The intention was to merge the scheme for houses for doctors and nurses and the hospital and ambulances with the General Nursing Service scheme. The Medical Scheme was to continue to be administered centrally. A further new scheme, Nursing Services for the Western Isles, was to be placed with the District Public Health Authorities, and not the County Council, as the others were. The continuing need for economy delayed the development of the new merged schemes and the preparations for placing the schemes in the hands of the local authorities.<sup>45</sup> However, the principle had been agreed and with the agreement of the SBH the Treasury therefore reversed the decision made in 1914 to centralise the administration of the Fund, which at the time had been made against the wishes of the HMS Board. It was clearly both a cost-cutting exercise and designed to remove those immediate areas of responsibilities from the Treasury and the SBH, which recommended that the County Councils, rather than the 51 small Public Health authorities, would be more effective and could also monitor the general coordination of the work. Local contributions were to be increased to 'the utmost extent possible' and this move placed the responsibility for that on to the localities.<sup>46</sup>

The Housing Scheme (which had been merged with Ambulances and Hospitals) was the first to be addressed. A survey in 1914 had estimated that £57,000 would be required for those purposes. However, by 1920 the sum had increased three-fold, as Table 6.10 demonstrates. An additional 20 per cent was also required to be added for the preparation of sites, fencing and services, etc., and fittings and equipment for nurses houses, which raised the amount required to £190,000. Inflation had significantly reduced the value of the Fund and the accumulated balances were not sufficient to meet the requirements in 1920.

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<sup>44</sup> *Report, SBH, 1921, p.103.*

<sup>45</sup> TNA, T161/1304, HMS, Administration of Grant, 1920-21.

<sup>46</sup> TNA, T161/1304, Internal letter to Mr Hurst from J.D. Bunford, 20 October 1920.

**Table 7.3 Pre-War and 1920 estimates for capital expenditure**

	Pre-war estimates	1920 estimates
28 houses for doctors	£18,820	£53,000
78 houses for nurses	£30,760	£73,000
For hospitals	£5,050	£20,000 (incl.
For ambulances	£2,550	ambulances)
Total	57,180	146,000 +

**Source: NRS, HH54/73, Houses: 1914 and 1919 costs.**

The Board (SBH) requested approval to use the balance of the Fund for The Housing Scheme. The Treasury estimated that of the £190,000 required to implement the scheme, £40,000 was to come from local contributions and £114,000 only from the accumulated balance, leaving a shortfall. The remaining £36,000 in the Fund was to be made available to meet the increased costs of the Medical and Nursing Schemes, removing the need to ask the House of Commons for any additional money in the Estimates of 1920/21.<sup>47</sup> The de-centralisation was to lie in abeyance for a considerable number of years, due to the lack of resources.

During 1920 the SBH carried out a comprehensive review of the HIMS. The only two schemes which called for review were the Medical Scheme of modified fees and the Nursing Scheme. The review noted that the Medical Scheme cost £22,500 a year, which was made up of £12,500 and the old insurance grant of £10,000 a year. In addition, the Supplementary Grants added £12,500, so the total cost of the Medical Scheme was £35,000.

In 1914 it had been estimated that the 100 existing nurses should be increased by an additional 110 fully trained nurses. By 1920 46 nursing associations supported by the Fund employed 114 fully trained nurses. The Nursing Scheme cost approximately £5,500 a year, within the prescribed limits, but with heavier expenditure predicted in future years. However the Scheme was not fully operational, several areas in the islands did not have doctors, due mainly to the war.<sup>48</sup> The SBH considered that the scheme could not be developed fully for the provision of 215 nurses, which the Board

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<sup>47</sup> TNA, T161/1304, Internal letter to Mr Hurst from J.D. Bunford, 20 October 1920.

<sup>48</sup> TNA, T161/1304, Letter from SBH to Treasury with results of their survey of the administration of the Schemes, 6 August, 1920.

considered necessary, without adequate funding, which would cost in the region of £19-20,000 in total.<sup>49</sup>

The necessity for localities to contribute to the on-going and increasing costs of the HMS through the rates, fee payments by patients and support from charitable sources was constantly reinforced. No grants till then had been made from the rates and it was appreciated that the Highland counties were already carrying a greater burden on the rates than the rest of the country, out of proportion to the number of paupers. From the beginning of the war 74 of the 170 parishes in the Highlands had been forced to increase their salaries for parish doctors to retain existing doctors or to encourage new doctors when vacancies occurred. In 1920 12 parishes were paying £12 a head of those on the Poor Roll, 15 were paying between £5 and £10, 35 were paying £3 and £5 and 81 were paying between £1 and £3. The case was made that although the Board did not make grants to the parish councils, it did insist, as a condition of grants to their medical officer, that those high salaries were maintained and in some cases increased. Furthermore, where houses were required for doctors, although a grant from the Fund may have been available, a contribution from the parish council, both towards the capital cost and in annual maintenance charges was needed. To insist that parish councils reduced their salaries would have risked local alienation at a time when the HMS was being de-centralised. Furthermore, the Board had no power to compel parishes to increase their rates for maintenance of the Poor Law. The chairman of the Parish Council of Loch Broom wrote to the SBH in October 1920 protesting about the capital expenditure imposed on them by the requirement to provide a house for their doctor in addition to the salary of the doctor, which was 'at a much higher rate than that paid for Poor Law Services in more central areas'. The doctor's salary represented £2 5s per pauper. A house which was available for a doctor, required an HMS capital grant, requested two years previously. As a result of no house being made available the doctor was threatening to leave the parish.<sup>50</sup>

Increased fees, which would boost doctors' incomes, were effected from 1 January 1920. 'In order that the localities bear a reasonable share of the increased cost of medical service'. The initial fee was kept at 5s and subsequent visits were raised to £2 2s. Midwifery attendance was raised to £2 2s, the sum suggested by the BMA during

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<sup>49</sup> NRS, HH65/7, Correspondence between the Treasury and SBH, November 1920.

<sup>50</sup> TNA, T161/1304, Letter from Parish Council of Lochbroom to SBH, 1 October 1920.

their meetings with the Board. From the revised fees an increased local contribution of £5,225 was estimated from 145 practices which had agreements with the Board.<sup>51</sup>

Correspondence between the SBH and the Treasury continued throughout the early months of 1921, during which a new scheme for the institutional treatment of tuberculosis was agreed. TB was a source of great concern in the Highlands generally and was particularly serious in the Outer Isles and Skye. The extended correspondence was revealing in terms of Treasury attitudes to the HIMS:

I would...ask you to consider whether we should not now go back upon the original principle underlying the charges made under the authority of your Board for Medical Services, namely that of eliminating the element of distance and charging the man who lives 10 miles from a doctor the same as a man living next to him. This principle is terribly uneconomical, as indeed is the whole subsidy for Medical Services, and my own view is that a middle course under which a moderate charge for distance is made would be best. There will be no great hardship in expecting a man outside the two miles limit to pay an additional one shilling a visit and a man outside the five miles limit to pay an additional two shillings, and so on. Their expenditure on the average on a doctor will probably, even then, be decidedly less than that of an inhabitant living much closer to the doctor for he himself will be indisposed to pay more visits to outlying persons that are really necessary. Such a system moreover would fit in better with the scale of charges outside the subsidised area, particularly in the urban areas surrounding it.<sup>52</sup>

The comments above, contained in an internal letter to Hurst from G.L. Barstow, demonstrate a complete lack of awareness of the conditions doctors and patients faced in the Highlands, the level of poverty to be found in some Highland districts and the remoteness of some areas, where there were no urban areas surrounding them. The suggestion was quickly responded to by Jeffrey, who after reminding Hurst of the underlying principles on which the HIMS was established, stated that it would 'almost certainly give rise to Parliamentary questions.' Clearly, the Service was becoming viewed as unworkable within the available funds, and the Treasury were very unwilling to request additional funding in the Annual Estimates. De-centralisation was a way for the Treasury to encourage as much as possible out of the localities 'it is difficult to put a screw on these poor districts but I am afraid that our financial

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<sup>51</sup> *Second Report, SBH*, 1921, p.103; TNA, T161/1304, Correspondence between Treasury and BMA, 1920.

<sup>52</sup> TNA, T161/1304, Correspondence from Hurst (Sir A.W. Hurst KBE, CBE), Treasury Chambers to J. Jeffrey, SBH, January 1920.



position demands it.’ To retain control over expenditure the Treasury placed a limit on it and gave the SBH discretion as to how to spend it.<sup>53</sup>

The financial situation did not improve and in November 1920 several doctors in Shetland and Ross-shire notified the SBH of their intention to withdraw from their agreements with the Board, as they could not afford to work under the scheme of modified fees on the current terms. A letter from the BMA to McQuibban also made it clear that some doctors were charging higher fees than the agreed amount in Orkney, ‘Dr Duncan of Stromness informs me that the fee for visits in Stromness is 3/6d, and that for country visits the charge is 4/- a mile, e.g. 24/- for a visit 6 miles in the country’.<sup>54</sup> Others were also threatening to leave, persuaded to remain only till the level of the supplementary grant was known. It was due at the end of each year and if it was delayed it caused much discontent amongst the doctors.<sup>55</sup> The main area of grievance was the lack of parity between the Insurance practitioners of the South, ‘the Lowlands mileage payments having been substantially increased.’ On 10 March 1921 a wire was sent to the Treasury requesting the approval of the grants to practitioners ‘at the earliest possible date’ as ‘doctors were becoming very restive and threatening trouble.’ The Treasury reacted immediately by telegraph the following day agreeing to the scheme of distribution for that year. The Board accepted that it could not force doctors to work under the Scheme of modified fees and there was a realisation that if the scheme collapsed it would be very difficult to have it re-introduced, on terms the doctors would consider to be reasonable.<sup>56</sup>

The end of the war did little to alleviate the financial problems faced by the Service. While it had been successful in implementing the medical service, the difficulties caused by the post-war inflation continued to prevent the other schemes from being fully established. In February 1921 Jeffrey warned the Treasury that if the annual grant was not increased until after 1922-23 (it was 1929 before the Service was provided with additional resources) that there was a danger that the annual requirements of the schemes in operation would erode the balance, which sat at £114,000, which it was planned would be made available for the Housing Scheme. A letter from the North Knapdale Parish Council to the Board, in May 1926, requested

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<sup>53</sup> NRS, HH65/7, Letter from Hurst to Mr Jeffrey, 23 November 1920.

<sup>54</sup> TNA, T161/1304, Letter from Scottish Medical Secretary, BMA to SBH, 1 November 1920.

<sup>55</sup> TNA, T161/1304, Letter from SBH Secretary to Treasury, 10 February 1921.

<sup>56</sup> NRS, HH65/7, Letter from Hurst to Mr Jeffrey, 23 November 1920.

copies of posters or leaflets regarding the arrangements between the Board and doctors as it was of the opinion that, 'The conditions of attendance do not appear to be known or have been lost sight of'.<sup>57</sup> The Service was beset with dissent from doctors and was increasingly unable to fully develop its schemes. Within that context the first comprehensive review and report of the HIMS was produced by the SBH.

A Consultative Council on Medical and Allied Services, was established in 1920 by the SBH to investigate and make recommendations on 'the systemised provision of such forms of medical and allied services' for Scotland. In recognition of the special conditions there a separate Consultative Council on Highlands and Islands was established.<sup>58</sup> It contained representatives from throughout the medical and public health arenas, including the Duchess of Atholl, Lady Susan Gilmour and Dr A.C. Miller, all past members of the Dewar Committee or the HIMS Board and with great experience of the Highlands. (The full list of members is at Appendix 10, Consultative Council on Highlands and Islands Personnel.)<sup>59</sup>

In 1927, it produced the first comprehensive review of the Service. Their remit was to consider to what degree the medical services in the Highlands and Islands provided under the HIMS provided an adequate service and whether the full range of schemes should be established. The Council examined in detail the background and workings of the HIMS. The numbers of doctors and nurses working in the Highlands in 1926 were 160 and 243, an increase of seven doctors and 50 nurses since 1925. The medical service was found to be extensive and adequate, attributed to the Fund having raised the standard of the service, with no districts which did not have access to a doctor. It recommended 'slight additions' to ensure 'reasonable adequacy of service'. The Nursing Service was deemed to be patchy, with wide variations across counties; some having a full and 'almost complete service', others with few trained nurses and some with virtually no nurses at all. The Council recommended that 'inequalities of treatment' between districts should be removed with little delay. The need for doctors to be fully versed in professional matters was considered vital. Sufficient time for them to be able to attend post-graduate courses (as well be able to have holidays) with fees covered, was recommended as a condition of holiday relief grants. Both the

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<sup>57</sup> NRS, HH65/3, Letter from North Knapdale Parish Council, May 1926.

<sup>58</sup> Scottish Board of Health Consultative Council on Medical and Allied Services, *Interim Report, a Scheme for Medical Services for Scotland, (MacAlister Report)*, 1920, p.9.

<sup>59</sup> *The Scotsman*, 31 January 1920, p.11.

numbers of qualified nurses and their organisation required to be improved, including 'better means of transport'. Assistance for hospitals and ambulances was found to be negligible. The report recommended 100 additional beds and related equipment, a new Cottage Hospital in Lochgilphead and x-ray machines for every hospital. Hospital support included the Northern Infirmary in Inverness, to enable it to provide services comparable to those in the Lowlands. Continued assistance to parish councils for doctors houses was to be given and the improvement of houses for district nurses was considered a priority. Specialist services already available in a number of areas, including Zetland, Lewis and Harris, and six or seven additional specialists were recommended for the remaining Highland counties. In remoter, less populous areas such as the Uists and Barra, a practitioner with some surgical experience was recommended as an alternative. Consultants, oculists and dentists were also required. Laboratories and clinics and telegraph and telephone facilities were also mentioned and recommended. The Special Emergency Scheme was to be continued and the Fund used to assist with the treatment of tuberculosis.<sup>60</sup>

The Consultative Council concluded that to enable a complete medical service an annual expenditure of £120,000 was required, which included £42,000 for the medical service for grants for 160 doctors and £7,000 for the Nursing Service, estimated at £200 per nurse. In comparison to the Dewar Committee's estimate of £42,000 it is clear why the HIMS struggled to develop its schemes over the period from 1915, when the initial schemes had been approved. The difference in the requirements perceived to be needed can be explained by the insufficient data available to the Dewar Committee, 'they had to proceed on what was really guess work' (which the Dewar Committee had admitted) and the rise in prices during and following the war.<sup>61</sup> The SBH agreed that an increased grant was required, though not to the extent of £120,000 and recommended that to facilitate a fully developed service £103,000 was necessary. £10,000 of that total was to be charged against the National Insurance Fund. The annual recurrent charge to the Exchequer therefore would be £93,000, a considerable increase in the annual Grant. The Treasury were unwilling to provide such a significant increase as 'the Scottish Department for Health would therefore be accumulating a balance at our expense in the earlier years.' In the years up to 1919-20 income of the Fund was 'consistently in excess of expenditure', from that year, the

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<sup>60</sup> TNA T161/1304, S2433/2, Report of the Consultative Council on the Highlands and Islands, 1927.

<sup>61</sup> TNA T161/1304, S2433/3, Letter from DHS to Hurst, 10 June 1929.

reverse was true and the balance was eroded year by year.<sup>62</sup> However, after discussion, it was agreed to provide an additional grant, which would be voted each year.

### **7.3 The transfer of the HIMS to the Department of Health for Scotland (DHS), 1929-36**

Consequently, on December 20, 1929, in the House of Lords, the Royal Assent was given to the Highlands and Islands (Medical Service) Additional grant Bill, to be voted annually by parliament according to specified need.<sup>63</sup> On the inception of the HIMS additional grant act, 1929, the Secretary of the DHS, in a letter to Hurst, summed up the Highland situation, which many in the Treasury appeared to find difficult to grasp:

...while the new grant system will be of the utmost assistance to local authorities in the Highlands in the discharge of their statutory obligations, the new Act will not greatly affect the circumstances of the people of the Highlands as a whole seeing that the main considerations governing their economic welfare – soil, weather and location – are unfortunately beyond the powers of Parliament.<sup>64</sup>

The HIMS had been surviving in part on the accumulated balances of earlier years, which were becoming depleted. From 1929, the Service, being realistically funded, was able to make realistic long-term plans in relation to the other schemes, which had been lying, virtually in abeyance, since 1915. The establishment and report of the Highlands and Islands Consultative Council, was a masterpiece of strategy by the SBH, and provided an authoritative review by independent, respected individuals. As a result of the report the Treasury, though it would not increase the HIMS Fund, were persuaded to provide further resources on an annual basis.

During the same year the Local Government (Scotland) Act, 1929, abolished parish councils and transferred their functions to extended county councils. The legislation also provided ‘considerably increased’ grants to the County Councils, which reduced the burden on the rates and thus their potential to support the HIMS schemes. The Scottish Board of Health was superseded by the Department of Health for Scotland (DHS) which took over the administration of the HIMS. The new legislation was considered an opportunity to improve the ‘standard of housing and domestic life’ and

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<sup>62</sup> TNA T161/1304, S2433/3, Letter from Hurst to DHS, 10 June 1929.

<sup>63</sup> *Highlands and Islands (Medical Service) Additional Grant Bill*, 1929.

<sup>64</sup> TNA, T161/1304, Letter from DHS to Treasury, 10 June 1929.

the care of mothers and children, in conjunction with the general and specialist services provided under the HIMS.<sup>65</sup>

In 1929 the DHS requested additional funding as the balance of the Fund was not sufficient to meet all expenditure to the end of March 1930. It appealed to the Treasury in the hope that an increased grant could be made available for 1929. An additional sum of £30,000 was voted for that year, the first payment under the new legislation. The DHS noted that in previous years expenditure had been focused on the medical and nursing service and that their estimate for 1929 allowed for expansion of the specialist services in areas where it was needed the most.<sup>66</sup>

In that year the Service had agreements for modified fees with 155 practices and in addition 24 doctors received grants for insurance mileage only, 40 doctors, mainly from remote and insular practices, were provided with locums and 10 special arrangements were put in place for particular districts and islands. 173 nurses were employed by 73 grant-aided nursing associations. Progress in the remaining schemes was increasing: four specialists were supported by the Service in three insular districts; the Gilbert Bain Hospital, Lerwick, the Balfour Memorial Hospital, Kirkwall and the Lewis Hospital, Stornoway. A full-time surgeon, first appointed in Lewis in 1924 for an 'experimental' period of five years, was, after visits from the DHS, deemed to have been an 'unquestioned success' and was continued as a permanent service. A capital grant was also provided to the Belfort Hospital, Fort William, to contribute to a new operating theatre.<sup>67</sup>

1929 therefore was a turning point for the HIMS. Having been obstructed in its development since its inception through insufficient funding, from 1929 it was sufficiently funded to further develop the core medical and nursing schemes and the remainder of the schemes. Some variable development had taken place in the housing for doctors and nurses. Increased expenditure was made from £496 in 1916 to £4459 in 1925 to £2184 in 1929, during which year the provision of seven doctors and two nurses houses were supported by grants from the Fund.<sup>68</sup> Problem areas still existed and the requirement for local contributions was strictly adhered to by the Treasury; a

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<sup>65</sup> *First Report, DHS*, 1929, p.113-4.

<sup>66</sup> TNA, T161/1304/ S2433/3, Estimate of expenditure from HIMS Fund for 1929, from DHS to Treasury, 6 April 1929.

<sup>67</sup> *First Report, DHS*, 1929, p.117.

<sup>68</sup> TNA, T161/1304/ S2433/3, Appendix to Report of Consultative Council, Summary of Income and Expenditure from the inception of the Service to 1929; *First Report, DHS*, 1929, p.118.

proposal for the formation of a nursing association in Stromness, Orkney foundered when local contributions were not achieved.<sup>69</sup> Voluntary contributions fell over time, partly as a result of the requirement to contribute to national Health Insurance.<sup>70</sup>

However, the Treasury edicts were not always met with acquiescence; when the decision to evacuate St Kilda was taken in 1930, following the realisation at the severe condition of the islanders, the then junior minister, Tom Johnston, ‘...overrode the treasury on the cost of the evacuation to the mainland’, paying for the move from the Agriculture (Scotland) Fund. The Treasury had decreed that the islanders personal possessions, savings and livestock should be sold to contribute to the cost.<sup>71</sup>

Nevertheless, the long-term aims and objectives of the HIMS, and the available resources to achieve them, were, for the first time, reasonably equitable and attainable. News of the HIMS had spread across the world and in 1928 Leslie MacKenzie visited Kentucky where a Frontier Nursing Service had been set up, influenced by the services established in Scotland. A path breaking nurse, Mary Breckinridge, had visited Scotland to investigate how the HIMS and the Frontier Nursing Society was a testament to that.<sup>72</sup> (See Plate 12, Mary Breckinridge on horseback.)

One of the most important additions to the provision of services was the establishment of air ambulance service from 1933. The establishment of the first commercial air services in the Highlands and Islands, Highland Airways, based at Inverness, raised the question of whether they could feasibly be used to transport emergency patients to hospital. Highland Airways ran an ambulance service from c.1934 from South Ronaldsay to Stromness which contributed to income generated by the service, but was not connected to the medical services on the islands.<sup>73</sup>

Although by 1933 the majority of districts were ‘within the reach of reasonably adequate local services, both medical and surgical’, there were a number of remote and island districts with sparse populations, such as Tiree, Coll and Applecross, where

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<sup>69</sup> *First Report, DHS*, 1929, p.114.

<sup>70</sup> NRS HH65/7. Correspondence with SBH.

<sup>71</sup> I. Levitt, ‘The Scottish Office and St Kilda, 1885-1930’, *The Decline and Fall of St Kilda*, The Island Book Trust, 2005, p.51.

<sup>72</sup> *The British Journal of Nursing*, August 1928.

<sup>73</sup> I. Hutchison, ‘The Scottish Air Ambulance Service, 1928-1948’, *The Journal of Transportation History*, 3rd Series, 30, 1, 2009; TNA T161/1304/S2433/3, letter from DHS to Treasury about the potential for Air Ambulance service, 9 August 1933.

it was not practical or feasible to build a hospital or to provide specialist services. Doctors had for some time appreciated the potential of the development of an air ambulance service. The Tiree doctor stated 'it would be of value to the medical services of the isles to be able to count on aerial transport for cases requiring urgent and major operative interference.'<sup>74</sup> Conditions in those areas were still very challenging for doctors, which no amount of funding could eliminate. The DHS thought that there was potential, but that it was probably limited by the difficulties of landing and inclement weather experienced in those areas, and believed that as far as possible patients should be transported by more standard methods, 'by road and steamer'. Despite this they considered that it would be a useful alternative in districts where conditions made it possible. The DHS proposed to make arrangements with the local County Council or other local body, to which they would contribute to the fee of an air ambulance; the selection of cases to be chosen by the local doctor. An annual expenditure of £200 for those purposes was envisaged.<sup>75</sup>

The response of the Treasury was cautious but not opposed to the proposal. It estimated the cost of a journey of 60 miles to be around £5 and from Tiree and Coll 100 miles, where the DHS had proposed the initial flights could be based. Instead of a commercial service, he suggested that 'The Air Force ...could do the job, say one or two cases for a matter of £25 out of pocket (the officer's services are flying time.)' A previous example of Air Force activity was mentioned. It was suggested that the Air Force be asked if they would 'take up the job'. The response of the civil servant in the Treasury stated, with some trepidation, 'I think you should see this.' The case to which the former writer referred was the transportation of vaccine in an emergency by an RAF plane. The response to the suggestion 'strongly deprecate(d) any proposal that the Air Force should set up the nucleus of an air ambulance service' and noted 'Better keep the Air Force out of it'.<sup>76</sup> The Treasury duly approved the expenditure, if arrangements could be made with the County Councils, for the transportation of the 'poorer classes' to hospital by a commercial airline. In November 1933 the DHS issued the terms of its arrangements for an Air Ambulance Service, in which it agreed

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<sup>74</sup> *Glasgow Herald*, 19 July 1929, quoted in Hutchison, 'Scottish Air Ambulance Service', p.64.

<sup>75</sup> TNA T161/1304/ S2433/3, Correspondence regarding the use of commercial air services for the removal of patients to hospital in emergencies, 8 August 1933.

<sup>76</sup> A note in the margin 'I too', suggested that there was consensus on that issue in the Treasury. TNA T161/1304/ S2433/3, 16 August 1933.

to repay to the County Council two-thirds of the cost of the charges for patients unable to afford the fees themselves.<sup>77</sup>

The HIMS, with its increased income and greater ability to co-ordinate with the expanded and better resourced County Councils, was operating on a more stable and efficient basis. In 1936, when the Cathcart Committee, appointed ‘to review the existing health services of Scotland’, produced their report, they were generally positive about the service.<sup>78</sup> By 1936 the Grant in Aid received was £69,000, which included £10,000 transferred from the Scottish National Health Insurance Fund for mileage of the insured. The balance carried over was just under £2,000. Over £48,000 of that was allocated to the medical service for grants for 151 doctors and £19,000 was contributed to the Nursing Service. The expenditure on the Medical Service had remained fairly stable since the initial increase in costs during and after the war. In 1921, following the increase in the scale of fees, it cost £43,800, in 1926 £42,760 and in 1930 £44,190 was required. The Consultative Council had recommended £42,000 as being likely to be required for the full development of the Service, which appeared to be reasonably accurate.<sup>79</sup>

There were still districts where the topography and remoteness affected the level of service but the widespread discontent of earlier years had abated. A comparison of the report of the Cathcart Committee in 1936 with that of the Highlands and Islands Consultative Council in 1926 shows considerable progress in the intervening ten years. The Highlands and Islands Consultative Council reported the ‘great advance[in] bringing medical treatment within the reach of their beneficiaries [of the National Insurance and HIMS] to an extent previously unknown in the Highlands.’ It also reported a considerable lack of development in all schemes, requiring ‘...a need for State assistance towards a more comprehensive system of medical services that the Highlands and Islands at present possess’, which it attributed to ‘The altered conditions – medical, statutory and economic – since the institution of the Fund...’. The Cathcart Report attributed success to the Medical Scheme but, as the Consultative Council had ten years earlier, found that in respect of the Nursing Service, which in 1936 had 200 nurses employed in the Highlands supported by the HIMS ‘...there is

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<sup>77</sup> T161/1304/ S2433/3, Arrangements for Air Ambulance Service, 6 November 1933.

<sup>78</sup> *Report, Committee on Scottish Health Services (Cathcart Report)*, DHS, Edinburgh, 1936, pp.221-233, 288-290.

<sup>79</sup> *Cathcart Report*, pp.222-3; Report on Services assisted from the Highlands and Islands (Medical Services) Fund, Scottish Board of Health Consultative Council on Highlands and Islands, T161/1304/S 2433/2, 1926; *SBH Report, 1921 & 1926; DHS Report, 1930*.



still necessity for developments in this service, as a number of districts are without any nurse at all, while the general standard requires to be raised in some places'.<sup>80</sup> Advances in 1936 in the provision of nurses was the establishment of seven new district nursing associations in Orkney.<sup>81</sup> There was still however a more general need for more fully qualified nurses, as the Consultative Council had also reported.

The ability to attract good quality doctors and nurses was very much reliant on the provision of good quality housing. By 1936 approximately 50 doctor's houses had been provided with the assistance of the Fund. In addition to those nurses' houses which had received improvement grants, 16 new houses for nurses were proposed, to be funded jointly with loans from the Queen's Institute. The telephone service was extended in 1936 and telephones installed in doctors or nurses homes. A wireless link between the mainland and outlying islands of Skye, Caithness, Barra and Zetland was established, considerably improving communications in those remote areas. They included Foula, Papa Stour and other small islands where communication was particularly difficult. In addition to the increasing number of grants for Hospital and Specialist services, which the Cathcart Committee considered still to be inadequate in 1936, an increased level of professional development opportunities for doctors was provided, which was previously one of the shortcomings of working in the Highlands. A greater number of locums had been provided and in 1936 grants for surgeons located in the Highlands were made available for approved refresher courses.<sup>82</sup> Centralisation of specialist services was recommended and the development of an air ambulance service seen as a possible 'solution' for the more outlying areas, though the surgical services in Orkney, Caithness, Zetland, Lewis and Sutherland impressed the Committee.

The percentage of uncertified deaths, which had fallen from 10.54% in 1911-13 to 4.51% is revealing. Although in Scotland as a whole the proportion had fallen from 1.80% to 0.47%, the Cathcart Report noted that 90% of all uncertified deaths were still located in the Highlands. That figure clearly shows that in some areas the impact of the HIMS was limited. That there was a drop in uncertified deaths was encouraging, but the high proportion in the Highlands, which would have been more prevalent in the poorer and insular areas, represent deaths where no doctor was

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<sup>80</sup> *Cathcart Report*, p.224.

<sup>81</sup> *DHS Report, 1937*, p.96.

<sup>82</sup> *DHS Report, 1937*, pp.95, 97-98.

present or sought following the death. The Dewar Enquiry found that many instances of uncertified deaths occurred in the elderly sick where the fees of a doctor were considered a luxury. Those areas of continuing poverty were hidden within the more populated districts situated primarily in the Outer Isles and Skye, where high rates of tuberculosis continued.

Despite this, while the Dewar Committee reported medical services in the Highlands to be 'quite inadequate', the Cathcart Committee 24 years later found them to be 'reasonably adequate', acknowledging the considerable progress which has been achieved. It also considered that 'it cannot yet be said that the ideal has been achieved.' Doctors in some areas were still finding it difficult to collect their fees and defects in children, identified during school inspections, were not always referred to a doctor. A closer coordination with the public health services, including tuberculosis, venereal diseases, maternity and child welfare was suggested and an additional grant of £50,000 to facilitate those improvements. However, notwithstanding the defects and weaknesses raised, overall the Cathcart Committee concluded that the HMS was 'an outstanding success'.

Therefore, what did the HMS achieve and how successful was it? An assessment of the HMS necessarily includes a number of factors, including the numbers and quality of the doctors and nurses practising in the Highlands and Islands and if, and how that changed over time. The suitability and success of the administrative structures also has to be considered and what the situation might have been like without the Service.

In 1851 75 GPs were employed in the Highlands. By 1912 there were 170 doctors, many of whom had insecure incomes, poor working conditions and no job security. There were very few fully trained nurses. By 1935 153 doctors had arrangements with the HMS and 7 were employed directly by the Service at a cost of £47,500, 198 nurses were employed by 30 grant-aided nursing organisations at a cost of £18,500.

Though the numbers of doctors (entering into agreements with the Medical Service) remained fairly static, the Dewar Committee were correct in stating that few additional doctors were required. The quality of doctor working in the Highlands, however, was perceived as having improved, with younger doctors attracted by better working conditions and salaries, though salaries still lagged behind those in the more populous areas. However, it was a more secure minimum income, together with

improved housing and access to locums. The Service in the later years was able to be more flexible, for example, an island doctor 'whose practice comprised 'two islands separated by an uncertain sea passage, frequently dangerous in winter' contacted the DHS as he was finding it increasingly difficult to manage as he grew older. A special grant was provided to enable him to hire an assistant during winter and spring. The insular practices were amongst those most difficult to recruit.<sup>83</sup> Specialist services were established, including orthopaedics and gynaecology and a full time surgeon was employed at Lewis hospital in 1924. A proposed new hospital in Lerwick costing £45,000 was subsidised by the HMS by £36,000 and the general hospital in Inverness was developing into a hub for Highland surgery.<sup>84</sup>

However, the HMS was not trouble free and financial constraints dogged its establishment and development. The sum estimated by the Dewar Committee, of £42,000, was a serious miscalculation, even without the impact of the war and the inflation which followed it. It was a major factor in the inability of the Board to fully develop the schemes. The planning and administration required to develop the Service was complicated and required a higher level of funds to enable the individual agreements with practitioners to be successful. The efficiency of the administration provided by McQuibban and later John Jeffries, who, with their masterly, well-composed and tactful memoranda and letters, provided continuity and knowledge of the Service over time and ensured that the benefits of the available resources were maximised. The Civil Servants in the Treasury treated the HMS equitably with other funded bodies but failed to appreciate the particular circumstances which existed in the Highlands. Both during and after the war they sought to minimise expenditure to an extent which almost paralysed its development.

From the practitioners' viewpoint the HMS, for some, provided a real element of security and income. However, from the outset doctors complained to the central authorities about the administrative burden associated with HMS grants and the time it required. Claim forms required extensive details of the area of each practice, the boundaries to be marked on a map; a detailed statement of income from all sources; expenditure including travelling expenses; the cost of hiring means of transport; rent and other housing details and the cost of drugs purchased. It was considered to be an

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<sup>83</sup> *DHS Report*, 1933, p.75.

<sup>84</sup> Shearer, *The Highlands and Islands Medical Service*, p.101.

over-rigorous system which doctors claimed was onerous and time-consuming. Reactions to the announcement of the schemes were built upon long-standing dissatisfaction with the administration required of doctors.

The dissatisfaction was not short-lived as has been demonstrated. From 1915, following the announcement of the full range of the Board's schemes, significant discontent felt by many Highland doctors was voiced in the *British Medical Journal*. Though the preparation and announcement of the schemes was one of the Board's main achievements since its inception in 1913, their reception was at best lukewarm and in some areas actively hostile. The schemes were considered 'radical, sweeping and subversive', and were compared to problems experienced at the onset of the National Insurance Act 'marred by many of the same faults'. 'A feeling almost bordering upon dismay' was the reaction to the grant scheme.<sup>85</sup>

The *Cathcart Report* cited the sometimes insurmountable issues arising from remoteness and geography. It was also recorded that higher levels of calls to the doctor were made by the insured class than the HIMS class. The increase in the number of qualified nurses was a quantifiable success of the HIMS, which also provided support for doctors.

The Report of the Consultative Council on Highlands and Islands was a very astute strategy by the SBH. It provided a convincing argument for more resources, without which the SBH might have found difficult to negotiate. By 1945 the sum for the Nursing Scheme rose from £18.5K to almost £44k (used for District Nursing Associations, the building of houses and the purchase of cars) and 150 doctors who has entered into agreements with the Board were paid £58,854 in grants, £640 of that sum was to cover the cost of locums fees for 19 doctors. The DHS was considering how to implement the recommendations of the Spens Committee, which recommended a doctor's income of c.£1,300 a year in the Highland, considerably more than a Highland doctor was earning.

The service provided has been heralded as the 'forerunner of the National Health Service' and 'a charter for emancipation' for the doctors who worked within it. Doctors did benefit from a guaranteed minimum income and access to locums. Housing was increased and improved and specialist services were established,

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<sup>85</sup> NRS, HH65/6, Reported in Allocation Fund, General file.

including orthopaedics and gynaecology. However, in 1932 the future NHS was predicted at a Labour Party Conference ‘the Country’s health needs “can only be effectively provided by the establishment of a complete State Medical Service, giving everything necessary for the prevention of treatment of disease, free and open to all”’.<sup>86</sup> The HMS was not a free service for all, fees were levied, even if not paid, and local authorities were consistently, throughout the period, required to make a local contribution. It adhered to the key principle of the National Insurance Act which was consistent with self-help, as each individual or organisation was required to make a contribution. Finlayson reported on national insurance ‘... by being contributory, it would not result in entire dependence on the state, nor would it discourage thrift.’<sup>87</sup> The HMS mapped those values till it was subsumed into the NHS.

It was asked in *The Scotsman* as early as 1917 ‘Are we on the way to a State Medical Service?’ ‘Something in the nature of a State Medical Service has been introduced under the scheme of the Highlands and Islands Medical Service Commission’. Thus an extension of scope and not principle is all that might be required to inaugurate a State Medical Service’.<sup>88</sup>

Many of the problems surrounding medical and nursing services are related to remoteness, topography and scattered populations and the same issues have been recorded in all rural areas of North America, Scandinavia, and Australasia. While increased salaries, better housing and improved transportation and infrastructure and developments such as the air ambulance did ameliorate working conditions, doctors and nurses today still face many of the same issues, within the context of the NHS.

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<sup>86</sup> J. Stewart, ‘Ideology and Process in the Creation of the British National Health Service’, *The Journal of Policy History*, 14, 2, 2002, p.117.

<sup>87</sup> G. Finlayson, *Citizen, State and Social Welfare in Britain 1830-1990*, Oxford, 1994, p.184.

<sup>88</sup> *Scotsman*, 25 Sept 1917, p.4.

**CHAPTER 8**  
**‘THE MEDICAL SALVATION OF THE HIGHLANDS’<sup>1</sup>**  
**NURSING IN THE HIGHLANDS AND ISLANDS**

The improvement in the provision of medical services in the Highlands and Islands depended on a reliable supply of suitable well trained nurses, who fulfilled a crucial role in assisting and augmenting the work of the doctor. They were often the only point of medical contact with the population and were accepted as a familiar and accepted part of the community; many were from the areas in which they worked and were native Gaelic speakers. Doctors’ professional status and their frequent position as incomers, on the other hand, could set them apart from the general community, they were part of the elite of the community, with the minister and teacher. The conditions experienced in the remote areas of the Highlands had parallels within the UK and Ireland and in other parts of the world; Scandinavia, New Zealand, Australia, Canada, United States and other countries with remote hinterlands, faced the same challenges in the provision of health care. This chapter will examine the development and growth of district nursing within the Highlands, in particular, its increasing importance within the Highlands and Islands Medical Service. Nursing provision was, of course, important everywhere; in remote and sparsely populated Highland districts it was a vital element of health care provision and assumed distinctive characteristics. To identify the crucial role of nurses within the context of Highland medical provision this chapter will examine briefly the historical and historiographical background and nature and function of nurses in the Highlands, the training and recruitment, the funding and distribution of nurses; the conditions under which they worked and their working relationship with the general practitioners. Examination of those key issues reveals the difficulties experienced in developing an effective service in the Highlands and Islands throughout the period under examination and illuminates the essentially pragmatic stance adopted by doctors, nurses and their patients within the increasingly structured organisation of District Nursing associations in the often adverse circumstances of those isolated areas. Nurses were frequently placed in remote areas

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<sup>1</sup> The value of organised nursing in the Highlands was emphasised, if emotively, by Lord Lovat in his evidence to the Dewar enquiry, Q.2312, p.67.

in positions of responsibility which would have been considered unacceptable in the Lowlands and which were often considered difficult areas for doctors.

## **8.1 The Historical And Historiographical Background**

Nursing history until the early 1890s followed the Whig tradition. It charted the general development of the profession on a macro level, covering centuries rather than decades, and focused on the efforts of individuals, mostly belonging to the middle or upper classes, stressing their roles in lifting nursing out of the ‘dark ages’. Many of the earlier histories were written from within the nursing profession with little or no recourse to primary sources, and with an understandable aim to glorify the profession’s development.<sup>2</sup>

Abel-Smith wrote the first modern comprehensive history of nursing, while Davies, Maggs and N. & J. Parry opened up the subject in the later decades of the twentieth century by challenging the orthodox approach to nursing history.<sup>3</sup> They questioned the view that changes in nursing practice and organisation altered the status of women as nurses and argued that the developments of the nineteenth and twentieth centuries confirmed male domination of the medical profession. That view reflected firstly, nurses’ status within the medical profession and secondly, popular impressions of nursing duties. Nurses were seen as being ‘ancillary’ to doctors, not only by doctors themselves, but by the upper strata of the nursing profession and by those involved in their organisation and training. The language used to describe nurses promoted that attitude; contemporary literature caricatured them and they were either perceived as Mrs Gamp figures - gin-sodden wretches - or were characterised in highly sentimental terms; ‘Angels of Mercy’, having ‘a Holy Calling’, their duties having a spiritual aspect, their duty - to improve the moral character of society.<sup>4</sup> That stereotype can be seen within the Dewar enquiry and the Highlands and Islands Medical Service in the quotation heading this chapter, ‘The Medical Salvation Of The Highlands’, written by Lord Lovat. Since many of their duties were not far removed from domestic tasks – and nursing duties in the Highlands often included domestic work – it was considered by many to be akin to housework and therefore appropriate work for women, with the

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<sup>2</sup> Earlier histories include; M.A. Nutting and L. Dock, *A History of Nursing*, New York, 1907; Lady S.E.M. Jeune (ed.), *Ladies at Work*, London, 1893.

<sup>3</sup> B. Abel-Smith, *A History of the Nursing Profession*, London, 1960; C. Davies (ed.), *Rewriting Nursing History*, London, 1980; Christopher Maggs, (ed.) *Nursing History: The State of the Art*; London, 1987; N. Parry and J. Parry, *The Rise of the Medical Profession*, London, 1976.

<sup>4</sup> *The Call of the Nurse*, Edinburgh, 1926.

low status accorded to domestics. The changes in the nursing profession throughout the second half of the nineteenth and early twentieth centuries were substantial but did little to alter the basic premise that nursing was 'subordinate' to medicine rather than a bona fide part of the healing profession.

Much recent historical research into nursing and the medical profession has concentrated on the development of general nursing, particularly in hospitals, but a growing body of research has broadened the field to include gender studies and is both inter-disciplinary and international in its scope. Abel-Smith recorded the rise of the nursing profession in the context of general nursing. More recently the organisational and professional history of nursing in Scotland has been charted by McGann, Crowther and Dougall, which documents the development of the profession by the Royal College of Nurses and the transition of nurses from 'Angels of Mercy' to professional health care workers.<sup>5</sup> The international perspective is provided by Mortimer and McGann, which also addresses gender issues, 'the acceptance that women are nurses and nursing feminine...one of the embedded assumptions of the history of nursing...'. Nursing in the Highlands required more than 'respectability' in nurses who worked there, requiring a practical as well as professional approach to the work.<sup>6</sup>

Other works have charted the development of the Poor Law nursing service and midwifery at the national level, concentrating on English experience.<sup>7</sup> Until relatively recently little has been written on the development of the nursing profession or midwifery in Scotland. *Perceptions Of Change: An Oral History Of District Nursing In Scotland, 1940-1999*, a doctoral thesis by Rona Dougall and Reid's *Midwifery In Scotland: A History*, goes some way to enhancing the historiography.<sup>8</sup> Monica Baly's national study of the Queen Victoria Jubilee Institute, a major supplier of trained district nurses, many of whom were employed in the Highlands, gives a broad view of the development of the Institute, but focuses on the features of its organisation. It is

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<sup>5</sup> S. McGann, A. Crowther & R. Dougall, *A History of the Royal College of Nursing, 1916-90: A Voice for Nurses*, Manchester, 2009.

<sup>6</sup> Mortimer & McGann, (eds.), *New Directions in the History of Nursing: International Perspectives*, London, 2005.

<sup>7</sup> J. Donnison, *Midwives and Medical Men*, London, 1977; J. Towler and J. Bramall, *Midwives in History and Society*, London, 1986; R. White, *Social Change and the Development of the Nursing Profession: A Study of the Poor Law Nursing Service 1848-1948*, London, 1978.

<sup>8</sup> R. Dougall, *Perceptions Of Change: An Oral History Of District Nursing In Scotland, 1940-1999*, unpublished PhD thesis, Caledonian University, Glasgow, 2002; L. Reid, *Midwifery In Scotland: A History*, Erskine, 2011.



based on the English branch of the Institute and does not address the organisation of district nursing in Scotland.<sup>9</sup>

## **8.2 1890-1912: Handy women to Jubilee nurses**

In the Highlands and Islands where many districts and insular areas often had no resident doctor, nurses were potentially of great importance but were inadequate in terms of both quantity and quality. Moreover, the work nurses were required to carry out was varied and required greater flexibility than in more populous areas. In many districts, however, no nurses at all were available and the ‘handy woman’ was the only recourse. Nursing of the general population was, in this period, still frequently carried out by such unqualified women who had in the past, in the absence of a doctor, fulfilled the role of nurse, and more frequently midwife. Many old customs were still followed. Following the death of his father, Halliday Sutherland, a doctor himself, remembered, ‘At seven in the morning he died, and the nurse, without a word, opened one of the windows. It was an old Highland custom - to allow the spirit to depart’.<sup>10</sup>

In 1890 the majority of Highland nurses (and throughout Scotland) were local untrained midwives or ‘handy women’, local women with little or no training who attended confinements. They were also known as ‘skilly wives’ and ‘howdies’. A small proportion were ‘cottage nurses’, partially trained nurses with maternity training.<sup>11</sup> Although untrained the handywomen are considered by some to have fulfilled an important role in the Highlands, by accompanying and learning from women with experience and passing those skills and knowledge down generations.<sup>12</sup> This is illustrated in this oral excerpt from Shetland:

I had a grand-aunt [Meggie] who was the age I am now [80] when I was a teenager. She had no children of her own, never was married, a peerie body who was in attendance at many a birth. I asked her how it was she had taken up to be a howdie for she had no proper training. Apparently, her mother, Hannah, had been a howdie and when she began to get old she began taking Meggie along too...<sup>13</sup>

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<sup>9</sup> M. Baly, *A History of the Queen's Institute for District Nurses*, London, 1988.

<sup>10</sup> H. Sutherland, *The Arches of the Years*, London, 1933, p.208.

<sup>11</sup> *Dewar Evidence*, Q.16586-16591, p.103.

<sup>12</sup> Oral comments by Helen Bryers, Inverness, 2012. Author of ‘Midwifery and Maternity Services in the Gàidhealtachd and the North of Scotland 1914 to 2005’, University of Aberdeen, unpublished PhD thesis, 2010.

<sup>13</sup> L Reid, *Midwifery in Scotland, A History*, Erskine, 2011, p.9.

The income from attendance at births may also have provided a limited source of income, though the payment of fees would have been most likely to be paid in kind. Midwifery in Scotland was not regulated until the Midwives (Scotland) Act, 1915, and many unqualified women continued attending births till the 1950s, some with the consent of the doctor.<sup>14</sup>

The significance of inadequate nursing during this period was highlighted during the Dewar enquiry. For example, on the Uists in 1912 two nurses were employed on North Uist, one on Benbecula, with no nurses at all on South Uist. Barra had one Govan (partly trained nurse). Confinements in those areas were seldom attended by a doctor; of 60 confinements in 1911 the doctor on South Uist attended only 22, the remainder served by 'old women'. The doctor reported:

I can see the after-effects... (from untrained attention)...in the women of Eriskay. Invariably when I was called to them at first it was always in connection with some uterine mischief, and I got a whole number of them, one after the other, which showed that there must have been some mismanagement. There is no doubt that in Eriskay there have been after-effects from mismanagement.<sup>15</sup>

The Roman Catholic clergyman on Eriskay, Father John Macneil, in his evidence to the Dewar enquiry, could not recall any doctor attending a confinement over the previous seven years. The 'woman of experience' was over 80 years of age and was considered unreliable. On one occasion a confinement was attended by the clergyman and the schoolmaster, with the aid of a medical directory.<sup>16</sup> Father Macneil also stressed the 'great necessity' for nurses for 'ordinary nursing' (as opposed to maternity nursing) required to follow up doctors' visits. 'I have seen several people who died for want of proper nursing, more so than for want of medical attendance'.<sup>17</sup> The illustrations described raise the question again of a suggested resistance to the doctor and an adherence to the old established practice of calling a local woman to a confinement rather than a qualified doctor. Despite having two nurses; one Govan nurse and one maternity nurse, the doctor employed to cover North Uist and the surrounding islands reported to the Dewar Committee that the 'old skilly wife'...[was]..still to the fore'. Another nurse was deemed necessary to eliminate the

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<sup>14</sup> The Act established the Central Midwives Board for Scotland., which examined and monitored the profession and established a Roll of Midwives in Scotland. L Reid, *Midwifery in Scotland, A History*, Erskine, 2011, pp.21, 46.

<sup>15</sup> *Dewar Evidence* Q.20,155, p.403.

<sup>16</sup> *Dewar Evidence*, Q.20,744, p.415.

<sup>17</sup> *Dewar Evidence*, Q.20,446, p.409.

‘skilly’ nurse, although it was acknowledged that other districts were worse off.<sup>18</sup> (See Appendices 12 & 13 for a List of Nursing Associations in Outer Isles subsidised by Board, 1916 and a Queen’s Nurse’ account of duties in in the Western Isles, c.1920).

Wester-Ross, another isolated area, depended greatly on untrained nurses and neighbours for confinements. Again old practices remained. Even where a nurse was available local women were sometimes preferred. Of 45 confinements per year in the Kyle district the doctor was called to only eight, the remainder attended mostly by neighbours, despite the fact that a certified maternity nurse was employed. The maternity nurse was reported to attend confinements which were in ‘out-of-the-way places’, such as the gamekeeper’s house, whereas in the villages the nurse was not called in, neighbours being called instead.<sup>19</sup> Therefore isolation alone cannot explain the continued prevalence of the ‘Howdie’. Sometimes an uneasy or pragmatic partnership existed between the ‘old’ and ‘new’ forms of medical attendance. In the Applecross and Torridon districts where no nurse was employed the ‘doctors and the neighbours’ looked after confinements.<sup>20</sup>

In some cases, the distances involved and the difficulty of getting to islands in poor weather, or the sheer volume of work, prevented the doctor visiting all cases. In Shetland the medical situation was perceived as not being a problem. ‘It is a nursing problem.’<sup>21</sup> Most areas had few nurses, if any. On Bressay, for example, was one elderly nurse while Walls parish, on the west of the island had no nurse, the doctor visiting half the confinements and handy women the rest.<sup>22</sup> Yell, an island in the North, also had no nurse but had four or five ‘wise women’<sup>23</sup>

The level of acceptance or resistance to the doctor by some members of communities varied. In some areas the proximity and availability of a doctor influenced the concern felt at the lack of nurses. In Orkney, the majority of nurses were ‘handy women’ and ‘had no training except just from going out with the doctor’.<sup>24</sup> Orkney had only one trained nurse and three certified midwives throughout the county, but the situation

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<sup>18</sup> *Dewar Evidence*, Q.13768-13773, 13818, p.286-7; HH65/9, List of Nursing Associations in Outer Isles subsidised by Board, (including names of nurses, qualifications and experience), 1916.

<sup>19</sup> *Dewar Evidence*, Q.16586-16591, p.103.

<sup>20</sup> *Dewar Evidence*, Q.17097, p.356.

<sup>21</sup> *Dewar Evidence*, Q.7027, p.157.

<sup>22</sup> *Dewar Evidence*, Q.6797, p.152.

<sup>23</sup> *Dewar Evidence*, Q.7012, p.156.

<sup>24</sup> *Dewar Evidence*, Q.5047, p.122, Evidence of Dr R.P. Heddle, Medical Officer for Health for the County of Orkney.

was not regarded as giving great cause for concern as every island, except North Ronaldsay, had a resident doctor and the mainland was also well provided with doctors. Most districts had 'handy women' but the majority of confinements were attended by doctors; the attitude to the midwife was one of acceptance. 'A great number of the 'so-called' nurses here have gained experience by attending the sick - they are unqualified, but they seem to do very well.'<sup>25</sup> Throughout Caithness on the other hand, a 'large proportion' of births were carried out by local untrained women; 'they are known in the district as midwives, and they are called in, and they get paid for their services'<sup>26</sup> The untrained women attended mainly confinements and general nursing was absent, or carried out by neighbours.

Another important issue was the working relationship of doctors to nurses. Nurses often worked under the direction of the doctor, either formally, as for example in Perthshire, or informally, as in Lochcarron, Ross-shire where the nurse was employed by Lady Ann Murray, the local landowner, and was under no obligation to follow the doctor's instructions or advice. While trained nurses would seldom disregard the instructions of the doctor, untrained and partially trained nurses were often regarded as lacking in professional discipline and frequently ignoring doctors' instructions or advice. The doctor at Kyle confirmed that while certified nurses worked under his direction, uncertified nurses were 'more apt to do things on their own responsibility', and often 'would not do what they were told'.<sup>27</sup> Attitudes were influenced in some areas by doctors' personalities and although trained nurses were preferable over untrained, some doctors felt threatened by the prospect of more highly trained nurses. 'They (the untrained nurses) are always under the doctor and they answer much better in many cases than trained nurses. They carry out their instructions better than the trained nurses - at least we find that to be so in the country.' This reference to 'handy women' in Orkney illustrates the defensiveness felt by some doctors.<sup>28</sup>

Due to the nature of untrained nurses at this time, it is difficult to determine exactly either their numbers or their level of competence. Many were accepted as midwives by virtue of having a long service record and being accepted by, and taken under the wing of, the local doctor and working to his instructions.

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<sup>25</sup> *Dewar Evidence*, Q.5041, p.122. Evidence of the Medical Officer of Health for the County of Orkney.

<sup>26</sup> *Dewar Evidence*, Q.3982-3983, p.103.

<sup>27</sup> *Dewar Evidence*, Q.17361-17364, p.361.

<sup>28</sup> *Dewar Evidence*, Q.5049, p.122. Evidence of Medical Officer of Health for the County of Orkney.

Clearly, throughout the Highlands and Islands many cases of illness or childbirth were attended by unqualified persons, in the form of ‘handy women’, neighbours or others. The question of who if anyone, was responsible in the event of errors leading to deaths was raised during the course of the Dewar enquiry. For example, at Dunrossness in the north-west mainland of Shetland, the Baptist minister, who had some medical training, found himself in the position of performing operations in the doctor’s absence, and helping in difficult confinements when the ‘handy women’ could not cope. It was believed that while the minister could be charged with either manslaughter or assault in the event of anyone dying during his attendance, the ‘handy woman’ would not be equally liable. The minister’s position of responsibility in the parish relative to that of the untrained women undoubtedly increased his risk.

However, despite the risks involved, in the absence of trained nurses or midwives, such individuals appeared willing to continue to make themselves available in cases of emergency.<sup>29</sup> Deaths resulting from the attendance of untrained women in this period were a factor in their decline. On Foula where no nurse was available, a death from post-partum haemorrhage attended by a handy woman ‘...put an end to the handy woman’s offices in Walls district’.<sup>30</sup> The existence of such an office illustrates the dominance of untrained nurses in the Highlands and Islands at this time. Penalties for the attendance of non-qualified midwives at confinements did not come into operation until 1922. There is evidence that throughout the early decades of the twentieth century the role of the ‘handy woman’ evolved into one of providing domestic help for the mother after birth in the absence of relatives or friends, particularly after the introduction of the Midwives Act in 1915.

The decline of the untrained ‘handy woman’ can also be attributed to the decrease in successors of the same type. Many of the women described were old and on their death or retirement were increasingly not replaced by similar untrained women. The introduction of the National Health Insurance Act, which introduced Maternity Benefit, also hastened the rate of decline of the ‘handy woman’ in the Lowlands but which decreased at a slower rate in the Highlands, where fewer persons were insured.

The adequacy and acceptability of ‘handy women’ at the turn of the century could only be judged when the extent to which the doctor was called to attend births and the

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<sup>29</sup> *Dewar Evidence*, Q.7765, p.170.

<sup>30</sup> *Dewar Evidence*, Q.6860, p.153.

availability of other better trained nurses in the vicinity was taken into account. The circumstances described above show that in areas where little or no alternative existed they were still an essential, if less than ideal part of the community. They remained especially prevalent in the poorer west coast and insular districts, their presence evident well into the twentieth century.

The main obstacle to improved nursing services in these areas was financial. In the poorer areas of the West, North and South Uist for example, where the rating burden was heavy and the support of the local landowners was not forthcoming, great difficulty existed in raising funds to establish club systems or local nursing associations.<sup>31</sup> The burden of the rates in parts of Ross-shire was also cited as a factor preventing the establishment of nursing associations.

Areas which established nursing associations in the late nineteenth and early twentieth centuries subsequently had fewer 'handy women' as the demand for them was superseded by trained or, more generally in this period, semi-trained nurses. For example, the counties of Argyll, Sutherland and Perth all had well-established nursing associations, supported by the local gentry and voluntary bodies. In 1911 27 Jubilee nurses were employed in Argyll. Private trained nurses were supported by Mrs Mackintosh of Mackintosh at Moy and Lochaber and a free service was provided on the Estate. During a diphtheria epidemic she paid for nurses to treat those affected.<sup>32</sup>

Again though, the more remote and insular districts of those counties were largely without nurses. Table 8.1 charts the increase in nursing associations from 1890, when no nursing associations existed in the Highlands and Islands, to 1897 when ten nursing associations had been established, employing fifteen trained nurses.

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<sup>31</sup> *Dewar Evidence*, Q.20412, p.408.

<sup>32</sup> *Dewar Evidence*, Q.2165, 2238-9.

**Table 8.1 The Increase of Nursing Associations in the Highlands, 1890-1897**

Year	Association	No Nurses	Total
1890		0	
1891	Campbeltown	1	
	Inverness	1	2
1892	Campbeltown Nursing Society	1	
	QVJIN Inverness	1	
	QVJIN Lochaber	1	
	Lochbuie	1	4
1897	N Argyleshire N Assoc	4	
	Wick & Pultenaytown DN Assoc	2	
	QVJIN Inverness	2	
	QVJIN Lochaber	1	
	Lochbuie	1	
	Lerwick Sick Aid Society	1	
	QVJIN Inveraray Branch	1	
	QVJIN Oban Branch	1	
	Dunoon District Nursing Assoc	1	
	Stornoway	1	15

**Source: Annual Reports of the Queen Victoria Jubilee Nursing Institute, 1890, 1891, 1892, 1897.**

Skilled experienced nursing clearly benefited the whole community. One potential method of increasing the employment of trained nurses within districts was through the changed provisions of the Poor Law Act. In 1885 the cost of trained nurses for poorhouses was made a first charge on the Medical Relief Grant (MRG); half the cost of training was made a first charge against the grant. This only applied to poorhouse nurses and unlike England and Ireland where pauper nursing had been prohibited in 1897; in Scotland it was still permissible.<sup>33</sup> In the Lowlands changes in the Poor Law Act led to the employment of trained nurses in poorhouses, thus increasing the supply of trained nurses in Lowland areas. By 1901 half of Scotland's sixty seven poorhouses, the largest ones, had trained nurses. The implications to the Highlands, however, were that in common with other small rural parishes elsewhere that did not participate in the trained sick nursing grant, more than one-third of the grant was lost to them. In 1911 £7,187 of the £20,000 grant was absorbed for the provision of trained sick nursing by the larger urban poorhouses: the sum of £3,270 was utilised by

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<sup>33</sup> *Dewar Report*, p.56.

Glasgow and Govan poorhouses alone.<sup>34</sup> In the Highlands there was little increase in the numbers of trained nurses in poorhouses. Only eight poorhouses in the Highlands introduced trained nursing. The proportion of the Grant paid to the Highlands was therefore considerably diminished; in 1883 the Highlands received £4407 of the Medical Relief Grant, in 1911 they received £2807. Of the £7000 of the Grant used for trained sick nursing, the total amount of the nursing grant claimed in 1911 by the Highland poorhouses was £271.<sup>35</sup>

The lack of trained nurses employed in the Highlands and Islands was related to the sparseness of population, the majority of poorhouses were small with few inmates and meagre resources. They did not have the facilities to support probationers and the Highlands did not have an indigenous supply of nurses; the supply of nurses in the Highlands was inadequate.<sup>36</sup> The smaller rural poorhouses still relied on pauper nursing, usually pauper inmates. Not only did the numbers of trained nurses not increase but a substantial proportion of the Grant, the original purpose of which was to encourage an expansion of poor law medical relief by subsidising medical officers' salaries, was diverted with little benefit to Highland parishes.

Parish councils also had a requirement to provide nursing for the outdoor poor. Trained nurses, when employed, were sometimes available for the community but nursing of the outdoor poor was problematic as no subsidy was available from government funds and funds to pay them had to come from the rates. The numbers of outdoor poor increased during the later nineteenth century and there was also a growing resistance to entering the poorhouse. Despite the greater need for outdoor sick nurses, parishes employing a 'parish' nurse were uncommon.<sup>37</sup> No parish in the Highlands in 1903 employed a parish nurse. Outdoor nursing of the poor was carried out by untrained nurses, or more often by local women paid for a fixed period. 'It is a serious matter, in many cases, providing a nurse, and she is only obtained at great cost.'<sup>38</sup> Some parish councils contributed to local nursing associations and gained the services of a district nurse, where one was available, for the outdoor poor. A Jubilee nurse employed in a Thurso parish visited paupers, the parish council contributing

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<sup>34</sup> *Dewar Evidence*, Q.551(15), p.17. Evidence of John T. Maxwell, Secretary of the Local Government Board.

<sup>35</sup> *Departmental Committee on Poor Law Medical Relief (Scotland)*, *Minutes of Evidence*, Q.5952, 1903, p.208; See also Chapter 2, p.45.

<sup>36</sup> *Departmental Committee on Poor Law Medical Relief (Scotland)*, *Minutes of Evidence*, Q.5952, 1903, p.208,

<sup>37</sup> Most Highland poorhouses had vacant beds; Lorn poorhouse had accommodation for 234 inmates but the average number of inmates was 78.

<sup>38</sup> *Report of the Departmental Committee on Poor Law Medical Relief*, Volume 11, Evidence, 1903, p.169.



towards her cost.<sup>39</sup> Only one parish council retained the services of a nurse all the year round. She was paid 1s a day and an extra 2s on days she was in service. Other parish councils paid from £3-10 to ensure the treatment of paupers by the nurse.<sup>40</sup>

Some Parish Councils paid an annual sum to the local nursing association, if one existed, for the treatment of outdoor paupers. This could often constitute a lengthy battle of wills with the council. North Ronaldsay parish council resisted attempts to encourage them to contribute towards the cost of medical attendance for outdoor paupers from 1906 till 1908 (ignoring correspondence from the Local Government Board) and only finally agreed to pay £5.00 for the services of the Queen's nurse on the understanding that it was given directly to her and would not interfere with her wages from the Nursing Association. However, this example cannot be seen as the Council showing support for the nursing association as the following year a further request for a subscription to the nursing association was refused, the Council 'do not acknowledge having ever subsidised to the said association'. The payment was seen 'as an honorarium to the nurse for services rendered to the legal poor.' The Association was simply the medium through which the money was paid. Lack of funding for the nurse eventually led to the loss of the nurse whose absence was keenly felt. The nurse had not been replaced by 1920, the Board receiving 'numerous letters petitioning for a [fully qualified] nurse for the island.'<sup>41</sup>

Many parish councils simply relied on local women. Parish councils in Inverness-shire spent £2-3 on nursing for paupers, for the attendance by neighbours, 'most of the pauper nursing is done by neighbours who come and clean up their house for a small payment of money.'<sup>42</sup> In cases of infectious illnesses where the patient was not removed to hospital, the Medical Officer of Health for Perth would 'pay the mother' or get someone to do it.<sup>43</sup> Many parish councils did not subscribe to the nurse's salary; of the thirteen parishes in Sutherland only three or four paid the £5.00 requested for the nurse's services.<sup>44</sup>

There was therefore no informal arrangement under which the general public had recourse to a parish nurse similar to the arrangement whereby parish medical officers

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<sup>39</sup> *Report of the Departmental Committee on Poor Law Medical Relief*, Volume 11, Evidence, 1903, Q.4783.

<sup>40</sup> *Report of the Departmental Committee on Poor Law Medical Relief*, Volume 11, 1903, p.169.

<sup>41</sup> OA, CO6/2/1, Minute Book, Cross, Burness and Sanday, 1902-1930.

<sup>42</sup> *Dewar Evidence*, Q.2396, p.70, Evidence of Lord Lovat.

<sup>43</sup> *Dewar Evidence*, Q.17502, p.364, Evidence of the Medical Officer of Health for Perth, Dr John T. Graham.

<sup>44</sup> *Dewar Evidence*, p.197, Evidence of Daniel George, Hon. Treasurer of the Sutherland Nursing Association.

also functioned as general practitioners. Communities could not look to the Parish Council for the provision of nurses and no increase of trained nurses in the Highlands occurred directly from the actions of the local authorities.

Even where trained nurses in the Highland counties existed they were insufficient to requirements and in some instances were unwilling to nurse paupers. The parish medical officer for Canisbay, Caithness, expressed concern that the nursing of paupers in his area was 'very bad indeed' and reported, 'I have found it extremely difficult to find any nurse to attend to these pauper cases, even with advertising'. The Medical Officer of Health for Perth County admitted to being unaware of whether there was any poor-law nursing on any systematic scale. 'I don't know. I fancy that some of the parochial boards do arrange with the district nurses'.<sup>45</sup> The failure of parish councils to employ nurses for parochial duties removed from many districts a potential source of nurses.

As the untrained 'handy woman' gradually declined the numbers of partially and fully trained nurses grew. The Govan Nursing Home in Glasgow, provided training of a less intensive and thorough nature to that of the Queen Victoria's Jubilee Nursing Institute. The 'cottage nurses' as they were known, many of whom were natives of the Highlands and who returned to work there after training, were a vital supply of nurses to the Highlands and Islands. The cottage nurses held qualifications in midwifery and general nursing. Two grades of cottage nurses existed, their length of training distinguishing them from each other. In terms of qualifications they were in an intermediate position between nurses with maternity training only and fully trained nurses.

The first type of 'cottage nurse' was trained in nursing institutions for a period of six to twelve months in maternity and in general medical and surgical nursing. They also held a certificate of proficiency in maternity or midwifery work. The second type were nurses trained as above, but for a period of nine to twelve months, and holding a midwifery certificate either from the Central Midwives Board or from one of the recognized maternity hospitals. The Duchess of Montrose was President of the Govan Training Home. The Govan Nurses were primarily from a working class background and were trained for remote and rural areas. They were required to be working women

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<sup>45</sup> *Dewar Evidence*, Q.2340, p69, Evidence of Lord Lovat; Q.4680, p.116, Evidence of Dr John Webster Duffus; Q.17513-17515, p.364, Evidence of the Medical Officer for the County of Perth.

willing ‘to live contentedly in the homes of working class people.’ In addition to nursing they often also did domestic work. The location of the Training Home in working class Glasgow, beside the docks, was considered ideal as it had ‘very good material for training nurses because there [were] so many poor people there’. The cost of maintaining a cottage nurse was half the cost of a Jubilee nurse, which was an important factor in the poorer areas of the Highlands. For example, in Benbecula the cost of the Queen’s nurse was funded by £50 from Lady Cathcart, £15 from the Highland Ladies Club and the remainder from local contributions.<sup>46</sup> Where local benefaction was not available a cottage nurse was more realistic. In the eight years to 1912 33 nurses were sent north to work.<sup>47</sup>

**Table 8.2 Govan trained ‘Cottage’ Nurses sent to work in the Highlands, 1905-1912**

Sutherland	7
Argyll	4
Ross-shire	4
Inverness-shire	3
Perthshire	2
Forfar	2
Aberdeenshire	3
Hebrides	7
Mull	<u>1</u>
Total	33

***Dewar Evidence, Q.23,319, p.486.***

The Govan trained nurses received a varied critique. Lady Susan Gilmour, a member of the HIMS Board, the Scottish Board of Health Consultative Council and the Executive Committee of the Queen’s Institute, stated in a Report on Nursing Schemes, that:

the training given here is too short for a woman to learn more than midwifery, first aid, and the most elementary nursing. This is no disadvantage if it is fully realised by those who employ her, and she works under constant and expert supervision.<sup>48</sup>

If supervised, an advantage of employing a cottage nurse was in the cost. A cottage nurse was a ‘less qualified one, drawn from the lower class and her requirements and

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<sup>46</sup> *Dewar Evidence*, Q.382, p.12.

<sup>47</sup> The list includes Forfar, which would not normally be considered to be the Highlands. Areas of Aberdeenshire were remote, though that county was not part of the HIMS. *Dewar Evidence*, Q.23,319, p.486.

<sup>48</sup> NRS, HH65/9, Report by Lady Susan Gilmour on Nursing Services, 1915.

salary are both lower'. However, in the Highlands constant supervision, as later required by the HIMS, was rarely possible, unless in a hospital context. Lady Susan Gilmour was applying lowland urban conditions to the Highlands, and was also undoubtedly influenced by her involvement with the Queen's Jubilee Institute.<sup>49</sup>

Where only partially trained nurses were employed it was sometimes felt that the emphasis on maternity training rendered them inadequate to deal with 'all the general cases of sickness that arise'.<sup>50</sup> Although in many areas that was the case their flexibility was always appreciated. 'She has been a great boon to the people' the Roman Catholic clergyman commented on the partially trained nurse employed in Barra.<sup>51</sup>

On the other hand, many partially trained nurses' workloads surpassed that of those fully trained and their quality was not questioned. The Nursing Association of Kileamon and Knockbain, in the Black Isle, employed a cottage nurse. Her area covered thirty-one square miles, and a population of 782. She was, in the words of the Nursing Association, 'not fully trained, but fully occupied.' In 1915 she dealt with 80 cases and carried out 1114 daily visits. The Nursing Association reported that an examination of the books revealed that she was nursing a considerable number of general medical and surgical cases, as the doctor was on active service. This gives an indication of the responsibilities with which even a partially trained nurse had to cope.<sup>52</sup> A certain degree of pragmatism and common sense was therefore required when dealing with the employment of nurses.

The third type of nurses employed in the Highlands were the fully trained nurses. They were more expensive to employ and as already explained, not as readily available as partially-trained nurses. While it was generally accepted that fully trained nurses were most desirable, established experienced nurses with less formal training were considered to be of considerable use to communities. '...where you have got an established nurse giving satisfaction it would be quite impossible to dismiss that nurse [with whom the doctors are satisfied] because she has not had two years' professional training...'<sup>53</sup>

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<sup>49</sup> NRS, HH65/9, Report by Lady Susan Gilmour on Nursing Services, 1915.

<sup>50</sup> *Dewar Evidence* Q.20,627, p.413.

<sup>51</sup> *Dewar Evidence*, Q.20,635, p.413.

<sup>52</sup> NRS, HH65/9.

<sup>53</sup> *Dewar Evidence*, Q.2356, p.69, Evidence of Lord Lovat.

The fully trained nurses underwent a three year course in a recognized hospital with not less than 100 beds. They normally also held a certificate in midwifery and had undergone a six month supervised course in ‘district work’, either in the Queen’s Institute or in one of the Queen’s officially recognised training centres in Glasgow, or Dundee. By 1900 thirty two trained nurses were employed in the Highlands, rising to fifty by 1912.<sup>54</sup>

**Table 8.3 Location of Queen’s Nurses in the Highlands in 1900**

County-District		Number of Nurses	
<b>Argyll</b>	Appin	1	
	Ardrishaig	1	
	Bunessan	1	
	Campbeltown	1	
	Craignish	1	
	Dunoon	1	
	Easdale	1	
	Inveraray	1	
	Islay	1	
	Killeen	1	
	Kilchoan	1	
	Lochbuie	1	
	Shielbridge	1	
	Tarbert	1	
	Tobermory	1	
	Glencoe	1	
	Kilmartin	1	
	Loch Awe	1	
	Morvern	1	
	Glendaruel	1	
	Duart	1	
	Otter Ferry	1	
	Kilmun	1	
	Oban	1	24
<b>Caithness</b>	Wick	2	
	Thurso	1	3
<b>Cromarty</b>	Stornoway	1	1
<b>Inverness</b>	Inverness	2	3
	Lochaber	1	
<b>Orkney</b>	-	1	1
<b>Ross</b>	-	-	0
<b>Shetland</b>	Lerwick	1	1
<b>Sutherland</b>	-	-	0
<b>Total</b>			32

**Source: 12th Annual Report of the Queen Victoria’s Jubilee Nursing Institute, 1900.**

<sup>54</sup> QVJIN *Annual Reports of the Queen Victoria's Jubilee Nursing Institute for the years 1900 and 1912.*

### 8.3 1912-1929: The Dewar Enquiry and the impact of war

By the end of 1914 the HIMS was subsidising 30 nursing associations and 18 nurses. Many of those practicing as district nurses therefore were poorly trained, if at all. The slow but increasing supply of trained nurses in the early twentieth century was due in large measure to the increasing emphasis on training, though it was 1919 before the Nursing Registration lobby was successful in getting a Bill passed through Parliament. The political machinery of the different pressure groups campaigning for, or opposing registration, were associated mainly with hospital nursing, and had therefore little direct relevance to Highland doctors.

The Queen Victoria Jubilee Institute for Nurses was therefore the main source of the most highly trained nurses. It was established in 1887 from a gift of £70,000 by Queen Victoria from her Jubilee Fund to promote, from its income, nursing for the benefit of the sick poor. From this sum, £2000 was used to set up a Scottish Branch of the Queen Victoria's Jubilee Institute for Nurses in Edinburgh in 1889.<sup>55</sup> The original aim of the organisation was to provide highly trained nurses to care for the sick poor in their own homes, at no cost to the patient or to the patient's family. One of the fundamental principles of the Institute was that nursing should be free to those who could not afford it. 'No letters of recommendation are required for the nurses' services. Poverty and need of nursing are the strongest claim'.<sup>56</sup>

To qualify for training as a Queen's Nurse, potential trainees were required initially to have completed one year's training in a general hospital and were then given six months training as district nurses. Nurses going to country districts also trained for three months in a Maternity Hospital.<sup>57</sup> In 1893 the requirement of hospital training was raised to two years, and in 1906 it was raised again to three years.<sup>58</sup> All training costs were met by the Institute. Probationers without previous experience were also accepted and were put through the complete training by the Institute.<sup>59</sup> As probationers of the Institute they were closely monitored to determine their

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<sup>55</sup> QVJIN, *1st Annual Report of the Provisional Committee*, Queen Victoria's Jubilee Institute for Nurses, Scottish Branch, 1889.

<sup>56</sup> QVJIN, *Second Report, Scottish Council*, 1890, p.7.

<sup>57</sup> QVJIN, *Third Report, Scottish Council*, 1891, p.6.

<sup>58</sup> QVJIN, unpublished history of Institute, p.5.

<sup>59</sup> QVJIN, Training Home Committee Minutes, 1902.

suitability.<sup>60</sup> (Appendices 11a&b contain examples of a Queen's Nurse registration and work cards.)

On completion of training nurses were eligible to be placed on the Roll of the Institute. They also received a brassard and badge which distinguished Queen's Nurses from others. As Queen's Nurses they were then guaranteed a minimum salary with rooms, fire, light and attendance. The Institute set the salary level; in 1890 the annual salary was £35, and by 1920 it had risen to £60. Probationers were paid £5 per year for the first year and £10 in their second year. When they were trained Queen's Nurses were normally hired by Nursing Associations affiliated to the Institute. Such organisations were bound by the rules of the Institute. They had to undertake to comply with the Conditions of Affiliation, to pay the Nurse the agreed rate of salary and to provide board and lodging. They were not permitted to hire nurses other than Queen's Nurses.<sup>61</sup>

Even after training Queen's Nurses were closely monitored. Nurses in the remotest areas of the Highlands were inspected twice a year by a Superintendent of the Institute, and were expected to conform to strict standards regarding procedures and the wearing of their uniform.<sup>62</sup> Their future was also considered. In 1906 a Contributory Pension Fund for Queen's Nurses was proposed and was put into operation in 1914. Fund – raising was carried out to boost the capital in the Pension Fund and additional finance was occasionally available. For example, in 1920 the Edinburgh Red Cross donated £3000 to the Pension Fund.<sup>63</sup> Although the pension was meagre Queen's Nurses were in effect better off in many ways than doctors practicing in the Highlands, for whom no contingencies for old age were available.

The social composition of the Council influenced the type of nurses accepted for training. Girls of 'good moral character' were sought and they were carefully vetted to ensure they were suitable candidates. The preferred age of probationers was 22, when it was considered they would be sufficiently committed to the profession. Although there was no entry examination to the Institute their educational record was appraised. Applicants were declined entry if:

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<sup>60</sup> QVJIN, Scottish Branch Council Minute Book, 1895.

<sup>61</sup> QVJIN, *Second Report, Scottish Council*, 1890, p.14.

<sup>62</sup> QVJIN, Registration and Work cards record regular (twice yearly) Superintendents' visits to very remote areas with comments about the nurses' dress.

<sup>63</sup> QVJIN, unpublished history of Institute, p.7.

they did not appear to be sufficiently educated, or were in such a social position that we thought they could not be sufficiently educated... If they have left school at fourteen and have not troubled about their education since, then I would not think they were sufficiently educated.<sup>64</sup>

As well as proof of educational ability character testimonials and health certificates were required by all applicants. The social background of applicants was also a factor determining their entry into the Institute.

They mostly come from the farming class. A good farmer's daughter has generally a very good education, and then she has been taught to work, which is a very important thing. I don't care to take servants unless I cannot help it.<sup>65</sup>

Examination of the Registration and Record of Work Cards of Queen's Nurses which recorded all personal details and employment experience, (See Appendices 11a & 11b), shows that while those entering training at the Institute were from a broad social spectrum they were mainly the daughters of the artisan and middle classes. A sample of the occupations of fathers of nurses included; a colliery manager, a master plumber, and a retired police sergeant.<sup>66</sup> From the scant evidence available the majority of lower working class girls who trained as district nurses appeared to have done so at institutions such as the Govan Nurses' Home, where they went through six to eight month's training.<sup>67</sup>

In 1889, the Institute's first year, eight nurses were trained at the Institute. By 1900 two hundred and twenty five fully trained Queen's Nurses were employed throughout Scotland of whom 32 were engaged in the Highlands and Islands. After a fall in the number of recruits in 1916-1918 'when most nurses as they qualified offered their services to the Army Authorities' applications for training resumed, although numbers were less than required, and 110 nurses were trained in 1921.<sup>68</sup>

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<sup>64</sup> *Departmental Committee on Poor Law Medical Relief (Scotland)*, Cd.2022, 1904, Minutes of Evidence, Q.6182, p.217. Evidence of Miss Wade, Superintendent of the Scottish District Training Home under the Jubilee Institute for Nurses.

<sup>65</sup> *Committee on Poor Law Medical Relief (S), Evidence*, Q.6188, p.217.

<sup>66</sup> QVJIN, Registration and record of work cards of all nurses trained as Queen's Nurses, c1898-present. A useful source of information on eg., social background, religion, previous occupation. The QVJIN was quite explicit in this. Girls were very carefully chosen. Background, education, character etc. were all taken into account when girls were being considered as probationers. See also evidence of Miss Wade to the Departmental Committee on Poor Law Medical Relief, 1904.

<sup>67</sup> *Dewar Evidence*, Q.23,217. Eg., Reference to Queen's Nurse. 'You cannot expect her to make herself so generally useful in a poor house as one of those other nurses [Govan Nurse].'

<sup>68</sup> QVJIN, Typescript article referring to 'The Story of the Queen's Nurses '(c.1905), by a Member of the Council, c.1921.



**Table 8.4 Number of Nurses Trained Annually at Queen Victoria's Jubilee Nursing Institute, 1889-1921**

Year	Numbers trained
1889	8
1899	33
1809	39
1919	65
1921	110

**Source: Typescript article referring to 'The Story of the Queen's Nurses' (c.1905), by a Member of the Council, c.1921.**

The work of the Institute did much to raise the status of the district nurse. The nurses were widely praised and the Institute found difficulty in training sufficient nurses to meet the demand.<sup>69</sup> The educative aspect of the nurses' work, that is, to teach the poor the 'moral values' of thrift, temperance and cleanliness derived from the sympathy that was expressed towards the 'deserving poor'.<sup>70</sup> The strict training and moralistic values instilled into the Queen's Nurses was, however, subject to modification in the practical reality of the remote and sparsely populated areas of the Highlands and Islands.

Despite improvements in training and the increase in the supply of trained nurses achieved by the Queen Victoria Jubilee Institute, nursing provision in the Highlands in this period was generally inadequate in terms of numbers of nurses employed, and their distribution and qualifications. Only a small proportion of nurses in the Highlands were trained nurses and the standard of professional nursing as measured by qualifications and professional experience could therefore be regarded as low.<sup>71</sup> The Dewar Enquiry found the existing supply of nurses to be inadequate, that their efficiency suffered from lack of organisation and that conditions in general were not conducive to encourage nurses to Highland employment.<sup>72</sup>

The foremost assistance to Highland nursing services after 1912 from the Medical Service Fund came from grants and subsidies paid to the training agencies and nursing associations which enabled trained nurses to be employed. The organisation

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<sup>69</sup> QVJIN, History of Institute, p.5. The Institute declared in 1908 that it could not cope with the demand for nurses.

<sup>70</sup> *The Call of the Nurse*, Edinburgh, 1926.

<sup>71</sup> *Dewar Evidence*, Q.5049, p.122.

<sup>72</sup> *Dewar Report*, p.24, 1912.

of nursing services however continued to be a structural weakness and remained largely under the control of *ad hoc* voluntary groups.

One reason for the lack of progress was the disruption to the plans of the HIMS by the First World War. Chapter 7 detailed the impact of the War on medical services. The demands of war intensified shortages of medical personnel and both nurses' and doctors' workloads grew as their practices increasingly covered larger areas. Following the war, suggestions were also made that VADs should receive training as district nurses, to relieve the acute shortage. (The HIMS had already employed partly trained nurses and VADs.) The idea was met with hostility by the Royal College of Nursing, which fought to prevent the encroachment of semi-trained nurses into the profession. An article in *The British Journal of Nursing* declaimed:

Should these changes find nurses in an unorganised position, it will be another proof to the Government that we nurses are a negligible body of women to be dictated to at the whim of the Ministry of Health [SBH], they will continue to regard us as a quiet, passive, unimportant detail, easily exploited, easily oppressed, and not worth bothering about. The employer will be set free to make arrangements he may choose for his work, and to drive what bargains he may choose with individuals. Because of his superiority in economic strength, the result will be that our salaries will be entirely under his control, and he can accept the Red Cross suggestion of VADs as district nurses. The idea of semi-trained nurses for the Highlands and Islands has been advocated by Members of Parliament...the only reason in favour of the idea is the cheapness of their services. Think what nursing duties in the Highlands and Islands must mean. Struggling to pull pneumonia or typhoid patients back from the jaws of death; converting a cottage room into an operating theatre at an hour's notice; coping single handed with puerperal mania...or battling with an epidemic of influenza, such as was recently experienced at St Kilda. Is this to be relegated to VADs with a smattering of experience gained in war hospitals? The most efficiently equipped woman would hesitate to accept such responsibilities.<sup>73</sup>

Another contributor had stated several years earlier, 'It was difficult to attract nurses, partly due to the lack of suitable housing, but the difficult working conditions, especially in winter '...snow, ice, bitter winds...sleet...and roads impassable by torrents from the hillsides make the journeying from patient to patient one of hardship'. 'Nursing work in the Highlands of Scotland is not eagerly sought after. It is not the pleasant life that it is sometimes considered by city cooped-up nurses.'<sup>74</sup>

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<sup>73</sup> *The British Journal of Nursing*, 25 December 1920, p.355.

<sup>74</sup> *The British Journal of Nursing*, 25 January 1913, p.71.

Neither examples above would have the result of encouraging nurses to seek employment in the Highlands, but show the strength of feeling by the RCN, who were seeking to improve training and conditions of work for nurses and increase the professionalisation of nursing. Later submissions to the *British Journal of Nursing* make it clear that the perception with which nursing as a profession was viewed ‘...quiet, passive, unimportant detail, easily exploited, easily oppressed, and not worth bothering about...’ would only be challenged by strong professional organisation. ‘Salvation cannot be brought about by a mere handful of already overworked women straining their utmost in isolated groups. We must unite in one strong union.’<sup>75</sup>

In the post-war period the HIMS found itself crippled by the realities of inflation and lack of manpower and this substantially affected many of the proposed projects. Schemes to develop nursing, hospital and ambulance, and specialist services, and to build custom-built houses for nurses and doctors, were put into abeyance and the ability to attract well-trained nurses in the future was therefore jeopardised. Inflationary pressures emphasised to an even greater extent the importance of voluntary contributions from local authorities, other local bodies and individuals. Acceptance of this is evident in the actions of the HIMS in the post-war period. The major thrust of the Board in relation to nursing services was to co-ordinate voluntary sources of income. To investigate how this could best be achieved the Consultative Council on the Highlands and Islands included in its investigations nursing organisation, but also encompassed the provision of houses for doctors and nurses, specialist services and hospital and ambulance services. It is an indication of the emphasis placed on nursing provision that by far the greater part of the work carried out by the Council was in this area.<sup>76</sup>

Another aspect inhibiting nurses from working in the Highlands was the continuing shortage of houses for nurses. In this period also the role of the nurse was extended, her work incorporating Public Health duties, such as maternity and child welfare, health education and the examination of school children, etc. The financing and maintenance of the Board’s schemes remained a constant problem.

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<sup>75</sup> *The British Journal of Nursing*, 25 January 1920, p.355.

<sup>76</sup> Atholl MSS, 7/1, Papers relative to the Highlands and Islands Medical Service Consultative Committee, 1913 and 1920-22.

Within the financial limitations placed on them the Medical Service Board were able to achieve some successes. The Board were responsible for placing district nurses on the most remote islands of St Kilda, and Foula, both of which had previously had recourse to neither medical or nursing services. The numbers of trained nurses employed in the Highlands grew, largely due to the subsidies made available by the Medical Service Fund, and nurses were more evenly distributed throughout the Highlands, although areas without nurses still existed. As will be seen however, this improvement arose principally through more nurses being available to cover a greater proportion of the Highlands and not primarily as a result of the more efficient use of the various voluntary resources.

**Table 8.5 Numbers of nursing associations and nurses subsidised by the Medical Service Board, 1914**

	Associations	Nurses
<b>Shetland</b>	3	
<b>Perth -Highland</b>	6	
<b>Argyll</b>	1 (N Argyll Nursing Assoc.)	
-Ardnamurchan		2
-Cowal	1	
-Mull		2
-Lorn	1	
<b>Inverness</b>		
-Aird	3	
-Badenoch	1	
-Lochaber	5	
-N Uist		2
-S Uist	2	
-Skye	3	
<b>Ross &amp; Cromarty</b>		
-Easter Ross	1	
-Mid Ross	3	
-Western District		2
-Lewis		10

**Source: TNA, HH65/5, Papers relating to the Allocation of the Medical Service Fund.**

Of the 224 trained Queen's Nurses in Scotland in 1903, only thirty-nine were employed in the Highlands. Thirty of those nurses worked in Argyll. This reflects the fact that Argyll was the only Highland county to have an organised Nursing Association, affiliated to the Queen Victoria Jubilee Institute. Of the other six

northern counties Caithness and Inverness each had three nurses, Orkney, Ross and Cromarty and Shetland each had one and the county of Sutherland had no trained nurses.<sup>77</sup> Six of the nine nurses not employed in Argyll were resident on islands; one on Tiree, and North Ronaldsay and two on Mull and Lewis.

**Table 8.6 Numbers of Highland districts with Queen's Nurses in 1900 and 1912**

County	1900	1912
Argyll	24	31
Caithness	2	4
Invernesshire	2	10
Orkney	0	2
Ross & Cromarty	1	1
Shetland	1	2
Sutherland	<u>0</u>	<u>0</u>
<b>Total</b>	30	50

**Source: Annual Reports of the Queen Victoria's Jubilee Nursing Institute for the years 1900 and 1912.**

Several explanations are available for this. One is that they were especially valuable if a doctor was not available, as on North Ronaldsay and Tiree, as otherwise the community had no medical provision at all. In such instances the doctor would call on stated days or on the request of the nurse. The other explanation is that islands were a 'manageable' area in terms of size. It was believed that in the more remote and sizable parishes a nurse would not be able to cover the distances involved. For example, in 1917 Sutherland had 15 nurses. Of those 12 worked from a burgh or village on the sea coast. The remaining three worked in the inland centres of Tulloch, Rogart and Lairg. The vast area in the interior of the county was therefore without any regular nursing service.<sup>78</sup> It was not unheard of for nurses to cover very long distances in their work in other remote areas. In Cape Breton in the 1930s Nurse Phyllis Jane Lyttle travelled almost 10,000 miles a year within Nova Scotia, from her base in Baddeck.<sup>79</sup>

Very few nurses (or doctors) had cars, though the incidence increased throughout the decades of the twentieth century. (See Plate 14, District nurse, Shetland, c.1930.) A nurse as an alternative to a doctor in a parish such as, for example, Ardnamurchan was simply not feasible. The problems a doctor would face with a sick patient at one end

<sup>77</sup> *Report of the Departmental Committee on Poor Law Medical Relief*, Vol.1, Cd.2008, 1904, p.216.

<sup>78</sup> Atholl Ms, 7/4, *Report on Hospital and Nursing Services in Scotland*, 1917, para.109.

<sup>79</sup> S. Mullally, 'Between Community and State: Practicing Public Health in Cape Breton 1938-1948', *Acadiensis*, p.106.

of the parish and another 25 miles away at the other end, in the winter with frost and snow and limited hours of daylight, would be an almost insurmountable task. Those difficulties in the attendance of patients were not likely to be solved with a nurse. Several nurses would be required for which funding was not available.<sup>80</sup> Moreover, the Institute specified that the nurses' work area should cover two miles, although in many cases this was not adhered to strictly.<sup>81</sup> By 1917, although Ardnamurchan had four nurses, the scattered population presented problems to efficient nursing and the service appeared to be 'scarcely adequate'.<sup>82</sup>

This also helps to explain why so many trained Highland nurses were employed in Argyllshire. Eight were employed on islands and as mainland Argyll contained the least remote and arduous terrain the remainder would not meet the extreme conditions present in other Highland counties. Many of the probationers (nurses in training) were from the Highlands. The numbers from Argyll were also boosted by the efficient organisation of the Argyll Nursing Association which sent nurses to the Institute for training, many of whom chose to return to Argyll afterwards. Likewise nurses were sent from the Stornoway Nursing Association to be trained and to return to work in Lewis.<sup>83</sup>

When Queen's Nurses finished their training they were bound to serve the Institute for two years. They could apply for certain areas but were under obligation to go where the Institute decided to send them. When a nurse was required by a nursing association they would contact the Institute who would send a suitable nurse. It is a measure of the training and discipline of the nurses that they never refused to go where they were told. 'Sometimes they pull rather a long face, but still they go where they are sent to'.<sup>84</sup> The District Committee who employed them provided the funds for the nurse's wages and had direct control over her, but had to agree to keep the rules of the Institute, as had the nurse. This was a safeguard for the nurse's benefit. On several occasions nurses were withdrawn when the proper amount was not paid.<sup>85</sup> The nurses were also inspected twice a year by a Superintendent to ensure that they were not becoming lazy in discipline and dress; they had to wear their uniform at all times

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<sup>80</sup> Atholl MSS, 7/4, *Report on Hospital and Nursing Services in Scotland*, 1917, Evidence, p.141.

<sup>81</sup> *Report on Hospital and Nursing Services in Scotland*, Evidence, p.217.

<sup>82</sup> Atholl MSS, 7/4, *Report on Hospital and Nursing Services in Scotland*, para 254, 1917.

<sup>83</sup> Atholl MSS, 7/4, *Report on Hospital and Nursing Services in Scotland*, Evidence, p.219, 1917.

<sup>84</sup> Atholl MSS, 7/4, *Report on Hospital and Nursing Services in Scotland*, Report, p.218, 1917.

<sup>85</sup> Atholl MSS, 7/4 *Report on Hospital and Nursing Services in Scotland*, Report, p.218, 1917.

when on duty. Those stringent regulations only applied of course to a very small proportion of nurses. Other nurses were funded by individuals or voluntary groups. Their distribution was haphazard and led to inefficient use of nursing resources. The establishment of the Scottish Branch of the Queen Victoria Jubilee Institute paved the way for improved district nursing provision in Scotland and marks an important stage in the improvement of medical services in the Highlands. However, in terms of numbers trained the process was at first slow and it took a number of years for the newly qualified district nurses to become freely available throughout Scotland.

Poor organisation arose as funding was dependent on ‘the voluntary effort of individual benefactors’ and ‘philanthropic agencies’.<sup>86</sup> In some areas nursing associations developed gradually from what were originally informal philanthropic bodies. Their efficiency and breadth of organization varied and they were still almost totally dependent on voluntary donations. The Sutherland Nursing Association established by the Duchess of Sutherland was such a body.<sup>87</sup>

The provision of nurses through such associations was maintained by donations from various sources. Small irregular donations from parish councils or district committees, and fees for the services of nurses were the least productive. Subscriptions from members of the associations, normally from 2s. to 10s., for which they were entitled to either a free service or reduced fees generated some income. The main source of revenue, however, was contributions and donations from members of the general public. The Ladies Highland Association, an organization associated with the United Free Church, provided grants to train nurses. From 1895 the Association spent over £3000 for that purpose, subscriptions obtained by collectors and boosted by a grant from London.<sup>88</sup> A breakdown of the income of the Sutherland Nursing Association for the year 1911 reveals the *ad hoc* nature of revenue collection for nursing services

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<sup>86</sup> *Dewar Evidence*, Q.329-337, p.11.

<sup>87</sup> *Dewar Evidence*, Q.9208-9, p.196.

<sup>88</sup> *Dewar Evidence*, Q.329-337, p.11.

**Table 8.7 Income of the Sutherland Nursing Association, 1911.**

	£
Donations & subscriptions	
within county	541
Subscriptions outwith county	20
Fees	132
Parish Council contribution	<u>10</u>
Total income	946

**Source: Dewar Evidence, pp.196-7, Evidence of Daniel George, Honorary Treasurer of the Sutherland Nursing Association.**

In addition, they received £35 from the Churches' collections and interest on dividends of £15. Of thirteen Parish Councils in the county, only two had contributed to the Association in seventeen years.<sup>89</sup> Contributions and donations from the public were more common from families with young children than from the elderly. A greater and more lucrative proportion of nursing associations' revenue, however, was forthcoming from proprietors, landowners and other well-to-do members of the community, such as shooting tenants.<sup>90</sup> It was reported that without the 'wealthy people in the county, the Association could never be run'.<sup>91</sup> For example, the four nurses of the North Argyll Nursing Association were 'mostly paid for by the proprietors'<sup>92</sup>, while in Inverness County the wife of The Mackintosh of Mackintosh, the owner of large estates in the county, supported nurses in Lochaber and Strathdearn.<sup>93</sup>

Thus the effort of private individuals and agencies helped ensure that some nursing provision was available in the Highlands which otherwise would be absent. Voluntary donations were however an insecure means of funding nursing provision: a regular annual contribution could not be guaranteed and those providing the money often dictated the terms of service. By the end of the second decade the level of voluntary funding by private bodies was in decline:

There are practically no contributions from charitable sources for the support of medical service in the Highlands. It is the case that certain landed proprietors and others who previously contributed to the support of medical and nursing services have either reduced or withdrawn their

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<sup>89</sup> *Dewar Evidence*, Q.9276, p.197.

<sup>90</sup> *Dewar Report*, p.21.

<sup>91</sup> *Dewar Evidence*, Q.9273, p.197.

<sup>92</sup> *Dewar Evidence*, Q.19,349, p.386.

<sup>93</sup> *Dewar Evidence*, Q.2240, p.65.



subsidies but as these subsidies were purely voluntary the Board have no power to enforce their continuance.<sup>94</sup>

The subsidies were withdrawn ‘in some cases’ when the proprietors were obliged to contribute to the National Health Insurance Scheme in respect of their employees.

The philanthropy of the upper classes, providing funding for nursing was not all-encompassing, and its purpose was, in many cases, primarily to ensure they themselves had recourse to a nurse when necessary. ‘One of the difficulties in the way of reform is, that big subscribers do like their own people looked after, and therefore like control over nursing arrangements’.<sup>95</sup> This is also clear regarding the provision of funding for doctors. In Arisaig, of the three properties in that parish the services of the nurse were available only to those living in the property owned by the nurse’s benefactor.<sup>96</sup> Evidence was cited of patients in one district requiring treatment while a nurse in a neighbouring district was unemployed. The Duchess of Portland for example, provided nurses for her estate in Caithness. There were no charges for their services but they were ‘confined absolutely’ to the Portland estate.<sup>97</sup> Only two counties, Sutherland and Argyll, had Nursing Associations organized on a county basis.

It is clear that the co-ordination and utilisation of the available means of funding nursing services was inefficient, leading to an uneven distribution of nurses throughout the Highlands. As a result the services of the nurses were often restricted to a certain locality. Only a small proportion of trained nurses working in Scotland were employed in the Highlands in this period. Trained nurses were employed in reasonably manageable areas to compensate for the lack of a doctor, for example on the islands. Nurses were generally in short supply, and despite an appeal by the Queen Victoria’s Jubilee Nursing Institute for funds to establish nurses in the Highlands and Western Islands, funding was almost totally dependent on voluntary contribution. The organisation of available nurses was therefore inefficient.<sup>98</sup> In 1900 there were 255 practising Queen’s Nurses in Scotland. Of that number only 32 were working in the

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<sup>94</sup> NRS, HH65/7, Letter from The Scottish Board of Health to the Secretary of the Treasury, Whitehall, August 1920, specifying the increases required to the Medical Service Fund.

<sup>95</sup> *Dewar Evidence*, Q.2342, p.69, Evidence of Lord Lovat.

<sup>96</sup> *Dewar Evidence*, Q.20,847, p.417.

<sup>97</sup> *Dewar Evidence*, Q.4385, p.111.

<sup>98</sup> QVJIN., 23rd Annual Report, 1911, p.11.

Highlands and Islands. By 1913 that figure had risen to 51. In addition, of course, there were partly trained nurses, midwives and handy-women detailed above.

The Dewar Committee found also that ‘no matter affecting the welfare of the people of the Highlands and Islands is more urgent than the provision of an adequate supply of trained nurses’.<sup>99</sup> They outlined the sources of revenue which supported existing services; sporadic contributions from parish councils, subscriptions paid to nursing associations, fees and finally the major source of income, donations from the general public. The *ad hoc* nature of the financial support, and the varying levels of qualifications evident within the nursing provision led to unequal distribution of nursing provision.

In regard to the supply of nurses the committee found ‘abundant proof of the inadequacy of the existing provision’.<sup>100</sup> As described above, it was evident that in many areas ‘it is only from the “skilly” woman or untrained neighbour that such help (nursing attendance in birth and infancy) can be obtained’. In addition effective nursing was required for the ‘following up’ of school medical inspections, which could forewarn and help prevent the worsening of childhood ‘diseases and defects’, to encourage and foster a knowledge of hygiene and beneficial dietary habits and to permit the earlier detection of illness.

In the light of the above conclusions the Dewar Committee made five broad recommendations for nursing services. The principle recommendation was that the existing voluntary agencies should be organised on a county or district level, but with local committees ‘to retain local interest and support’, thus relieving the imbalance throughout the Highlands and Islands between nursing supply and demand. An increase in the supply of nurses as a whole was recommended, particularly for insular communities, where remoteness prevented visits by a doctor. The Committee felt strongly that nursing should be regarded as ‘an integral part of the medical service’, the nurse being directly responsible to the doctor. Of course on many islands this was impossible, and although the nurse was not regarded as a replacement for the doctor, in such circumstances was forced to accept greater responsibilities than would normally have been the case. The provision of a suitable house or lodgings and the availability of the telephone or telegraph were the final recommendations of the

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<sup>99</sup> *Dewar Report*, p.20.

<sup>100</sup> *Dewar Report*, p.22

Dewar Committee in 1912, the former being essential in many areas in encouraging a nurse to remain in employment.

The Dewar Committee strongly advocated a well-developed integrated nursing service with an increased supply of qualified nurses with no lessening in the level of contributions made by the localities. The speed of the formation of the Medical Service Board in November 1913, shortly after the findings were published, indicates the lack of governmental opposition to the general recommendations. The Board believed that ‘no part of their work will call for fuller or more painstaking consideration’.<sup>101</sup>

One of the first acts of the Board was to request information from the districts as to what they considered to be ‘the special needs of the districts’. A Circular Letter (See Chapter 4) was issued in December 1913 to bodies and individuals in all districts of the Highlands and Islands.<sup>102</sup> It related to all aspects of medical services and emphasised that the Medical Service Fund was intended ‘as a supplement to the general medical service’ and was not intended to be a substitute or replacement for contributions to medical services from local authorities and other sources. ‘The Board are of the opinion that a well organised nursing service is the natural corollary of any efficient medical service but would view with concern any relaxation of local efforts’.<sup>103</sup> The section relating to nursing in the Circular Letter stresses this point and outlines the goals of the Board.

With a view to securing that every area shall have an adequate nursing service it is proposed to see that, in one way or another, nurses are established at convenient centres throughout the Highlands and Islands. It will be the endeavour of the Board to utilise the local nursing associations, where these exist, but in any case the system of nursing to be organised must be such as to meet the requirements both of the official and of the voluntary medical services so far as that may be found to be practical. The qualifications required of the nurses will vary with the circumstances, and the variation will largely depend on the practicability of close supervision of the work of the nurse or nurses by the medical practitioner of the locality. The duties of the nurse will be related alike to medical, surgical and midwifery cases. In many instances, perhaps in most, the headquarters of a nurse ought to be at the hospital of her district...<sup>104</sup>

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<sup>101</sup> NRS, HH65/9, Report of Board, 1915.

<sup>102</sup> *First Report*, HIMS, 1915, pp.6-9.

<sup>103</sup> NRS, HH65/7, Report of Board, 1915.

<sup>104</sup> *First Report* HIMS, 1915, p.8.

As seen above, prior to grants from the Highlands and Islands Fund being available the existence and development of a nursing service in the Highlands and Islands depended wholly on local initiative and the greater part of the funding was usually provided by private individuals or organisations. While Parish Councils, Public Health Authorities and Education Authorities were empowered to contribute to the funds of District Nursing Associations for nursing services which they required, very little support came from those sources. The extent of those contributions was seen as reasonable given the limited scope of work required. However, the Medical Services Grant of 1913, the Notification of Births (Extension) Act of 1915, the Midwives (Scotland) Act of 1915, the Education (Scotland) Act of 1918 and the Nurses Registration (Scotland) Act of 1919 could be regarded as opening the way for a higher standard of nursing and greater co-ordination of the existing private and public services.

The Medical Services Fund, Midwives Act and Nurses Registration movement provided funding and increased nursing qualifications, while the other Acts extended the duties of the Public Health authorities. Under the Notification of Births (Extension) Act, they were empowered to carry out schemes for Maternity Service and Child Welfare, whereby a midwifery service could be provided and arrangements made for attending expectant mothers, nursing mothers and children under five. Education authorities were required to make provisions for the medical inspection of school children and were empowered to provide medical, including dental, and nursing treatment. Parish councils were obliged to provide medical attention for the registered sick poor, and were also able to make arrangements for any nursing required.

In urban areas local authorities discharged their new duties by training and appointing health visitors who worked full-time on those duties. In the Highlands the employment of nurses or health visitors by local authorities was not feasible. Instead the main line of development was seen as lying in a proper co-ordination and unification of the private and public nursing services.

Much of the work in connection with the Maternity and Child Welfare Schemes could be carried out by district nurses with sufficient training in general nursing and midwifery, and the nursing of school children likewise. The Board believed that the

local administration of the various forms of the nursing service could be conducted more efficiently by a single body operating over a large area and employing several nurses than by a number of small Associations acting independently.

Figures available in 1917 give more information on the numbers of trained and untrained nurses in the Highlands and Islands. (See Appendix 14: Nurses employed in the Highlands and Islands in 1917). Regional variations are apparent. In 1917 Orkney, Caithness, Sutherland, Ross and Cromarty and Inverness were recorded as having 107 midwives and 77 handy women, Argyll had 29 handy women and Shetland, which had only two trained midwives other than district nurses had, in all the islands, 'women ..who may be called on in the absence of the doctor'.<sup>105</sup> Concern was still evident but paradoxically it was most vociferous in areas where most improvement had occurred, presumably because the quality of nursing having been markedly improved, had raised expectations of what was regarded as acceptable. For example, a medical officer from Argyll, the county with the highest proportion of trained nurses, complained about three Govan nurses, generally regarded as acceptable, who he complained were of little use, 'Could you make much of a medical man by giving him a third or a quarter of his course and no practical work in Infirmaries. How is a man different? In the face of what nurses have to do it is a sin to the girl and the district to employ such.'<sup>106</sup> Of course, his attitude may have been affected by shortages of nurses, caused by the War, but other instances confirm the acceptance of more highly trained nurses as the norm.

The numbers of untrained nurses were declining in the immediate post-war period. However, the onset of the War, as with doctors, affected the supply of nurses. As requests for nurses grew, often to act in place of a doctor for the duration of the War, the Board found it increasingly difficult to comply. 'The Board cannot promise that they can get one for some time because they are nearly as scarce as doctors'.<sup>107</sup> The difficulty of securing trained nurses was not diminished by 1919. However, the Board

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<sup>105</sup> Atholl MSS, 7/4, National Health Insurance Commission (Scotland), 1917. Report on Hospital and Nursing Services in Scotland, para 61, (Printed Report) It was noted that some of those women may have been subsequently registered as midwives following the passing of the Midwives (Scotland) Act, 1915.

<sup>106</sup> NRS, HH65/9, Letter from Dr P. Gillies to the Medical Officer Of Health of Inverness, (Handed in to the Board), 1916.

<sup>107</sup> OIA, CO6/11/2, Minutes, Papa Westray Parish Council, 26 August 1916.

had compromised on training to provide nurses. Since the beginning of the War the Board had supplied 38 new areas with nurses, mostly partially trained.<sup>108</sup>

#### **8.4 1919 – 1936 Growth and Consolidation**

As a result of the lack of progress of most of the Board's proposed schemes by 1920 described above, the Board assessed ways of increasing the efficiency of the Medical Service. On a survey of nursing conditions in the Highlands and Islands in 1914 it was estimated that the existing supply of 100 nurses required an additional 110 fully trained nurses. The number of nursing associations on the Board's annual grant list for 1919 was 46 and the number of nurses employed 114, 56 fully trained. The total expenditure from the Fund to nursing associations was approximately £5,500. It was felt appropriate that local authorities should contribute to any further increase in expenditure, arising 'through the general decline in the purchasing power of money'.<sup>109</sup>

As there was little prospect of the Medical Service Fund being increased at that time, it was recognised that any further improvement in nursing services was most likely to be gained through improvements in the organisation of existing services. In 1920 therefore, when the Consultative Council on the Highlands and Islands was created, its terms of reference included firstly, that the examination of which schemes put into abeyance during the War, should be developed. They were Scheme B - Nursing Services, Scheme C- Hospital and Ambulance Services, Scheme D - Houses for Doctors and Nurses and Scheme E - Grants towards Specialist Services. The second area to be considered was whether:

in view of the fact that over the area to which the Fund applies four-fifths of the entire Medical Service provided to the population is subsidised or maintained from public sources, the time has now come for the establishment of a public Medical Service, including nursing, available for all.<sup>110</sup>

This was a clear statement from the Scottish Board of Health in which it accepted that a comprehensive approach to medical care was necessary, which it was proposed would be fully funded by public funds. Moreover, this service was to be made

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<sup>108</sup> *Fifth Report, HIMS*, 1919, p.14.

<sup>109</sup> NRS, HH65/7, Memorandum, Review of Medical Service Schemes, p.3.

<sup>110</sup> Atholl MSS, 7/1, the Highlands and Islands Medical Service Consultative Council, preliminary papers. *Fifth Report, HIMS*, Board discussed fully the extent to which Highlands and Islands medical services were subsidised or maintained from public services, Cmd.169, 1919, p.9.

available to the entire population, not only the poorer sections of the community. The approach of the Council on this issue however, was to attempt to consolidate the various sources of voluntary support, mainly in the nursing sector, rather than formulate a new fully integrated system of medical services. This choice reflected firstly, the financial constraints placed on public spending, and secondly, the personal and professional interest in nursing of the majority of the Council members.

The Council was chaired by the Duchess of Atholl, who was also President of the Perthshire Federation of District Nursing Associations. The remainder of the Council consisted of members of various committees and public bodies, the majority of which had a particular interest in nursing. Lady Susan Gilmour, a member of the Medical Service Board, also served as a member of the Scottish Council of the Queen Victoria's Jubilee Nursing Institute, acting as Honorary Secretary from 1911.<sup>111</sup> Miss MacPhail, was Honorary Secretary of the Ladies Highland Association, Miss Margaret M White, Superintendent of the Queen Victoria's Jubilee Nursing Institute and James B Simpson, Vice President of the Sutherland Nursing Association and Secretary to the County Local Medical Committee. Those members all had a specific interest in nursing services. Mr MacLachlan, the Convener of the County of Argyll, Dr AC Miller, a former member of the Dewar Committee and Chairman of the Highlands and Islands Sub-Committee of the British Medical Association (Scottish Committee), Donald Murray, former Medical Officer of Health for Lewis and WJ Munro, Clerk to Easter Ross District Committee formed the remainder of the Council. The areas of Argyll, Sutherland, Highland Perthshire, Argyll and Lewis, all with well-established nursing associations, were therefore represented in the Council.

During the first meeting held in Edinburgh on 12 March 1920 it was agreed that the development of Nursing Services (Scheme B) and the Housing of Doctors and Nurses (Scheme D) were 'pressing matters which should receive first consideration'<sup>112</sup>

Council members were each scheduled to make enquiries throughout the Highlands and Islands to determine the nature, quality and efficiency of the available nursing services. They were to enquire about the adequacy of any existing service, including the availability of 'estate' nurses or other private arrangements which might have been made. The standard of housing for existing nurses and the means of housing new

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<sup>111</sup> QVJIN, 23rd Annual Report, 1911, p.8.

<sup>112</sup> Atholl MSS, 7/1, First Minutes of The Highlands and Islands Medical Service Consultative Council, 1920.

nurses was questioned as was the distance of existing or proposed nursing centres from the nearest telephone.

A pressing question was the extent to which local authorities such as Parish and County Councils, District Committees, Public Health and Education Authorities would be willing or able to contribute to improvements in nursing services. It was expected that the financing of any proposed nursing service would incorporate a contribution from local authorities and would not be fully supported by public funds. Special consideration was to be given as to whether improved training might stimulate the supply of nurses available for the Highlands. The last point indicates the concern felt about the inadequate supply of new nurses prepared to work in the Highlands and Islands. In addition to the information gathered above details were also sought from the Board on nurses employed in the Highlands who were subsidised by the Board, the areas in which, and by whom, they were employed, their conditions of service and housing, and any grants from the Medical Service Fund.

The Council spent four months gathering information and concluded that conditions had not substantially altered since the Dewar enquiry.<sup>113</sup> Due to the continuing fragmented nature of nursing provision in the Highlands and Islands, the paucity of nurses in some areas and the poor standard of housing provision for nurses 'it was resolved that the Board be advised that the Council are impressed with the urgent need for a proper co-ordination of the services provided by the various public bodies and voluntary organisations.'<sup>114</sup>

The supply of nurses was considered to be of great urgency. It was proposed that, through the agency of the Red Cross, VADs with experience of war nursing should receive training by the Central Midwives Board and the Queen Victoria District Nursing Institute to enable them to practise as district nurses in the Highlands. In July 1920 over 100 VADs were approved by a Select Committee of the Red Cross, which consisted entirely of professional doctors and nurses. However, by June 1921 only one VAD was able to take advantage of the training offered by the Queen Victoria's Jubilee Nursing Institute, due to delays in admission to maternity training.

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<sup>113</sup> Unfortunately, the bulk of the information gathered during the enquiry has not been retained. The ensuing minutes outline some of the findings.

<sup>114</sup> Atholl MSS, 7/1, 2nd Minutes of The Highlands and Islands Medical Service Consultative Council, 1920.



By 1922 the effects of the War were still evident, and due to the instructions of the Cabinet, which inhibited the development of any schemes which would increase either local or imperial expenditure, except on absolutely essential additions to existing services, it was not possible for the Board to bring into operation approved nursing schemes. It was not considered feasible to introduce schemes minus the power of rating. The Consultative Council were aware however, that the power of rating in schemes discouraged local authorities from action because the local authorities were aware that voluntary subscriptions would inevitably fall, the burden of the service then falling on the rates. ‘...so much of the nursing service is now on a rate or state-aided basis...that it is becoming increasingly difficult to get any substantial support from voluntary sources’.<sup>115</sup> Therefore, by 1922 little real advance had been accomplished.

The Medical Service fund was also under strain from the impact of the War on nursing salaries. During the early years of the War nursing salaries of £130, £110 and £100 a year were considered reasonable for fully trained nurses, partially trained nurses and midwives respectively. By 1917-18 however, nursing associations were being forced to offer much larger salaries. In 1919 the Queen Victoria’s Jubilee Institute for Nurses indicated that it was not prepared to supply Queen’s Nurses for the Highlands and Islands at salaries of less than £160 a year, out of which the nurses had to provide their own board and lodging, uniform, fuel and light. The Board were not in a position to meet the whole cost of the increases and asked local nursing associations to meet 50 per cent of the additional cost.<sup>116</sup>

From 1918 to 1928 limited progress was made and the number of nursing associations receiving grants increased from 38 to 72. The number of nurses employed by the associations rose from 98 to 174, although housing for nurses was still a considerable problem.<sup>117</sup> In 1926 the management and local administration of nursing services throughout the whole of the Outer Hebrides was finally placed directly in the hands of the public health authorities. The need of the district nurses was evident in their constant praise ‘one of the most valuable influences on the health of the community is

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<sup>115</sup> Atholl MSS, Minute, 20 June 1922.

<sup>116</sup> NRS, HH65/6, Papers relating to review of Medical Service Schemes, 1920.

<sup>117</sup> *Eighth Report, SBH*, 1928, p.64.

that of the district nurse'.<sup>118</sup> By 1934 many of the Hebridean islands without a resident doctor had a resident nurse.

**Table 8.8 Hebridean Islands with no doctor and a resident nurse, 1931**

Island	Population
Bernera (Lewis)	514
Scalpay (Harris)	636
Berneray (Harris)	331
Eriskay	420

**Source: HH65/31. Adequacy of the service in the Outer Isles, 1931.**

Each of those islands, although their population was small, had a resident nurse. Each was also equipped with a telegraph, which was available for summoning the doctor responsible for providing medical service. Although it could not be guaranteed that the doctor would always be able to attend in very bad weather it was considered that 'with a resident nurse available, and free to devote most of their time to one patient if necessary, it is believed that the needs of the people [were] reasonably met.'<sup>119</sup> The residents of Vatersay, with a population of 240, were also petitioning for a resident nurse. If approved, it was believed that a 'substantial annual grant' of £150 would be granted and later a capital grant for a nurse's cottage.<sup>120</sup> It was becoming accepted therefore that a resident nurse could be an adequate substitute in areas not sufficiently large to support a resident doctor. There was also scope for improving services by securing telegraph or telephone services for the islands, particularly smaller islands with small populations.<sup>121</sup>

By 1937 Orkney was heading towards a complete nursing service with South Ronaldsay, Sanday, Eday, and Westray all forming associations.<sup>122</sup> The numbers of district nurses regularly employed in the Highlands and Islands exceeded 200, with almost half using cars to visit their patients. Fourteen grants were given, raising the cost of the nursing grant by £2000.

By 1936, when the Cathcart Committee reported its findings, the nursing service had made good progress, with substantial increases in the number of trained nurses employed in the Highlands and Islands. Salaries were regarded as acceptable and

<sup>118</sup> SIA, *Annual Report of the Medical Officer of Health for Shetland*, 1928.

<sup>119</sup> HH65/31, Memorandum by the Department of Health for Scotland regarding the sufficiency of the Medical Service in the Outer Isles, p.2.

<sup>120</sup> HH67/31, p.3.

<sup>121</sup> HH67/31, p.3

<sup>122</sup> OIA, CO7/1/17, *Annual Report of the Medical Officer of Health for Orkney*, 1936.

many carried out their visits by car, removing much of the arduous nature of the work. The majority were provided with reasonable houses. In 1900 32 Queen's Nurses were engaged in the highlands and islands and by 1914, of the 107 nurses employed, only 47 were fully trained.<sup>123</sup> By 1937 this figure had increased to over 200.<sup>124</sup> Despite that the Cathcart concluded that among the improvements still required in 1936 were additional nurses and more cars to assist ease of travel, more 'refresher' courses and more and better quality housing for them. Those difficulties were similar to those facing the HMS Medical Service in 1913 and many continue to be a matter of concern today as outlined in the 1999 Arbuthnot Report, which recommended a redistribution of health service funding with a greater priority given to the needs of rural and island communities.<sup>125</sup>

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<sup>123</sup> Shearer, p.99-100.

<sup>124</sup> Dougall, District Nursing in Scotland, Unpublished PhD thesis, p.76.

<sup>125</sup> Dougall, District Nursing in Scotland, Unpublished PhD thesis, p.69.

## CONCLUSION

This thesis has examined in detail for the first time the establishment, infrastructure and development of medical services in the Highlands and Islands between 1843 and 1936. Between these two dates government intervention in the health of the nation increased in an unparalleled manner. Initially only available to those in receipt of poor relief, the development of public health services from the 1880s sought to transform the condition of rural and urban communities, improve health, reduce infectious diseases and improve hygiene awareness, water supplies and medical care, both in general practice and hospital care. Over that period, also, the medical profession became increasingly regulated and standards of training, education and practice improved. The numbers of doctors, trained nurses and hospitals increased and medical developments assisted progressively specialised medical practitioners in their work.

When the Scottish Poor Law was reformed in 1845 it provided the first state support for medical services.<sup>1</sup> It established the Local Government Board and the infrastructure for the system of poor relief that lasted till 1948. The new Poor law provided a salary for doctors to treat the registered poor and provided for many the only recourse to medical care. The Physicians' Enquiry Report of 1851 demonstrated for the first time the difficulties of providing medical services to the population of the Highlands and Islands, within the constraints of remoteness, difficult terrain and lack of medical personnel.<sup>2</sup> Few doctors were resident in the Highlands and ministers and other lay individuals carried out medical procedures or assisted the doctors. Many of the doctors were older, with little or no up to date medical knowledge. Salaries were low and doctors were reliant on the fee as parish doctor. General fees for treatment of the non-pauper population were often not paid. Working conditions were hard and the distances covered were long and arduous. The factors which resulted in poor medical services were therefore both geographical and economic.

In the mid-nineteenth century, fewer than half Highland parishes had Poor Law Medical Services. By the 1890s virtually all parishes provided a medical service, however rudimentary, and all were subject to the central control of the Board of

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<sup>1</sup> *Royal Commission on the Poor Laws*, Appendix No. CLIX. (C), 1843.

<sup>2</sup> RCPE, CK4, 11, Physicians' Enquiry, Royal College of Physicians of Edinburgh (RCPE), 1852.

Supervision.<sup>3</sup> Although the Board lacked the power to enforce its regulations it did establish the principle of centralised control of the Poor Law and was an important step in the later acceptance of the centralisation of the Highlands and Islands Medical Service, by fostering public recognition and acceptance to central control of this nature.

Increasing government activity grew during the later nineteenth century and was the result of a number of factors, both internal and external. Insecurities of the growing military and technological power of Germany during the later nineteenth century, bolstered by the crisis of the Boer War, fed growing doubts and unease about the basic tenets of the foundations of the classical liberal state, with its firm adherence to laissez-faire, free trade and commercial freedom. The internal features of strong parliamentary control, local self-government and a neutral civil service conflicted with the need for a modern approach to government and international relations, which the proponents of the 'National Efficiency' movement strove to achieve.<sup>4</sup>

Concurrently there was a growing recognition that poverty, sickness and destitution was not caused by moral failure but by urbanisation and the other consequences of industrialisation. The establishment of the Public Health movement during the second half of the nineteenth century was an acknowledgement of that.<sup>5</sup>

The conditions in the Highlands and Islands at the beginning of the twentieth century reflected, in part, the encompassing effect of 'technical maturity'; a peripheral area of Britain becoming economically stagnant, as its indigenous industry, always situated in the primary sector and therefore especially vulnerable, declined. The aging of the population structure of the Highlands alone increased the need for medical services. The land wars between landowners and tenants in the Highlands of Scotland (and Ireland) and the subsequent government mediation and legislation, provided important precedents for state intervention in the Highlands. *The National Insurance Act* in 1911 was the catalyst which led to the HMS.<sup>6</sup> Those workers who were insured under the

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<sup>3</sup> The Annual Reports of the Board of Supervision are available online at <http://parlipapers.chadwyck.co.uk/home.do>

<sup>4</sup> G.R. Searle, *The Quest for National Efficiency: A Study in British Politics and Political Thought 1899-1914*, 2<sup>nd</sup> Edition, London, 1990.

<sup>5</sup> I. Levitt, *Poverty & Welfare in Scotland, 1890-1948*, Edinburgh, 1988.

<sup>6</sup> *The Lancet*, November 30, 1912, p.1559; See also *Dewar Report and Evidence, Report of the Highlands and Islands Medical Service Committee*, Volume 1, Cd. 6559, 1912; *Evidence of the Highlands and Islands Medical Service Committee*, Volume II, Cd. 6920, 1913.

Act, which in the Highlands represented a small proportion of the population, could not be provided with adequate medical care. A solution was required and the decision to establish the Dewar Enquiry was made.

The findings of the Dewar Enquiry echoed those of the Physicians' Enquiry almost 50 years before.<sup>7</sup> Although some changes had been effected, for example, the establishment of the Medical Relief Grant (MRG), during its early years, did encourage parish councils to employ medical officers of health, many of the same problems remained in relation to the conditions of work and employment, for both doctors and nurses. Initially resistant to the concept of the Highlands as a special area, changes in perception occurred within the economic and social upheavals of the clearances, famine and emigration, and then the gradual move from sheep farming to deer forests, following the reduction of sheep prices from the 1860s.<sup>8</sup> One consequence of the change in perceptions of the Highlands was the development of greater public awareness and recognition, both within and outside the Highlands, that it required special attention. The disparity between the rural north and the industrialised central belt of Scotland was evident in many of the enquiries into Highland issues instigated by government in the second half of the nineteenth century. Within that context government awareness of, and intervention into the Highlands, took the form of special treatment in the form of dedicated public policy, including legislation leading to the establishment of special agencies, such as the Crofters Commission, the Congested Districts Board and the Highlands and Islands Medical Service (HIMS).

The Dewar Enquiry and the visits of the Committee to the localities raised public awareness of the issues surrounding the provision of medical service in the Highlands and the conditions to be found there.<sup>9</sup> It had generated goodwill for the potential for change. When the HIMS was established and the Board appointed there was therefore an anticipation of rapid improvement, for both the conditions and salaries of doctors and nurses and for improved medical care for those living in the Highlands and Islands. Because early progress was considerably delayed that goodwill was initially dissipated. The delays were partly the responsibility of the Board. The initial

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<sup>7</sup> *Dewar Report*, 1912; Physicians' Enquiry, Royal College of Physicians of Edinburgh (RCPE), 1852.

<sup>8</sup> E. Cameron, *Land for the People: The British Government and the Scottish Highlands, c.1880-1925*, East Linton, 1996.

<sup>9</sup> NRS, HH65/5, Highlands and Islands Medical Service, General papers, 1914.

circulation of the Circular Letter to all doctors was significantly weakened by the Board not placing a financial limit on the responses. By doing so it received suggestions for improvements which far overran the available grant of £42,000. It had the effect of raising local expectations and at the same time confirmed the magnitude of what needed to be achieved in each area to secure an effective medical service. The visits to the localities by the HIMS Board, so soon after the Dewar Committee also became a source of discontent, with a perception of the Board wasting time and resources.

However, the main issue which caused delays was the need to re-formulate the schemes following the delayed decision of the Treasury not to have a two-tier system within the HIMS. The decision to place the administration solely in the hands of the Board and not have local administrative committees required the complete re-working of new schemes, which delayed their approval till August 1915, almost two years after the HIMS was established. Dissatisfaction of doctors also arose from the administrative burdens of the grants, the increase both in their work load and the increases in the lowlands insurance payments.

The publication of the first report was also delayed and questions were asked in Parliament and in the *British Medical Journal*. By that point war had broken out and the finances of the Service was frozen. Although the unspent funds accumulated each year the lack of substantial progress was damaging to the reputation of the HIMS. Post war inflation prevented any progress in the schemes apart from the Medical Service, and that was limited in the early years to travelling costs. The Board therefore lost goodwill during the early years and from that point the BMA was intent on protecting its doctors from any reduction in their conditions of work or salaries. The impact of the war reduced the numbers of doctors and nurses available to work in the Highlands, preventing any real growth and post-war inflation. It also diminished the monetary value and potential of the grant to achieve wide-ranging developments. Consequently it reduced the impact of the new service. The need to amend and seek approval for the revised schemes following the slow decision of the Treasury and Scottish Office not to have local administrative committees, was cumulatively responsible for affecting public opinion and diminishing a level of confidence in the future potential of the service. Therefore those who have written on the 'unmitigated success' of the HIMS do so from limited knowledge of how the Service operated and

developed in practice. The HIMS struggled to establish the schemes after the war and through the 1920s. It was simply under-resourced.

The report of the Consultative Council for Medical Services in the Highlands and Islands was a crucial point in the development of the HIMS.<sup>10</sup> The report documented clearly that although some progress had been made in the Medical and Nursing Services, there were still weaknesses in the numbers and distribution of nurses, and that housing for both doctors and nurses were limited to refurbishment of older houses which were few in number. The Consultative Council recommended a sizeable increase in the Grant, and although the Treasury refused to increase the grant, they did agree to a variable amount which could be voted for each year. It was only after 1929, when the additional funding was made available and the HIMS was incorporated by the Department for Health for Scotland that real progress was made. The Local Government Act, 1929, in expanding the functions of the County Councils and increasing their resources made it possible for equitable partnerships to be established. By the 1940s the dissent from doctors had disappeared and the HIMS was acceptably established.

The HIMS was most successful in the most remote areas where doctors incomes were guaranteed and where the employment of trained nurses removed some of the burden from them. Improvements in the telegraph and telephone made it easier to communicate with patients and nurses, and the air ambulance service provided a vital means of transporting doctors to sick patients and in removing patients to hospital. The employment of Dr Shearer, an experienced doctor employed directly by the Board to act as a locum, who enabled doctors to have holidays and professional development, was a liberation for those who could benefit from his and other locums' attendance.<sup>11</sup> In addition fully trained nurses could ease the workload of a doctor. The requirement of the HIMS for nurses to be under the supervision of doctors at all times and on the other hand be placed in districts, such as islands, where no doctor was available, or in remote areas not close to the doctor was a paradox which was dealt with by adhering to the rule if it was possible and ignoring it if it was not. That

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<sup>10</sup> TNA T161/1304, S2433/2, Report of the Consultative Council on the Highlands and Islands, 1927.

<sup>11</sup> A. Shearer, 'The Highlands and Islands Medical Service, What it is and what it has done', *Transactions of the Edinburgh Medico-Chirurgical Society*, 1938.



demonstrates the pragmatism in the actual running of the HIMS, flexibility was essential.

The historiography, based mainly on the annual reports, does not reveal the complexities of the situation with which the Board was faced. Their accumulated knowledge and expertise on the Highlands could not predict the onset or impact of the War. The Treasury, having control of the finances, adhered firmly to the principle of local contributions, which, given the social, economic, cultural and geographical environment of the Highlands and Islands, was unrealistic. Services under the Poor Law and Public Health Acts were under strain throughout the 1920s and the continued philanthropy of landlords in the support of nursing and medical services could not be relied on in the long term. The HIMS Fund may have been a disincentive to continuing their benefactions, perceiving the Fund as an alternative source of funding which relieved them of their responsibilities. That response would have been a logical response to the National Health Insurance Act, which increased their statutory outgoings.

The Highland population, though the majority were not in a position to benefit from the National Insurance Act, were unique in the UK in the provision of reduced fees within an improved medical service. However, the HIMS did not provide the whole income, the National Health Insurance, contributions from local authorities, other local bodies, voluntary agencies and benefactors, all contributed to the development of the Service. That was one of the underlying principles, from which the Treasury and Scottish administrative bodies never deviated.

Was the HIMS a precursor to the National Health Service (NHS)? Just as it has been argued that the Liberal reforms laid the foundations for the creation of the welfare state some forty years later, the HIMS has been cited as also being an important step in that direction. It was unique in providing low cost care to the poor, but those entitled to reduced fees were clearly delineated as the non-registered poor, the crofter and cottar classes and the dependents of insured individuals. It was not a free service to all and those who, before 1913, had paid the standard fee of the doctor, continued to do so. It was rather, an example of the modification of the Victorian self-help ethic within the context of a publicly-funded subsidised service for a particularly vulnerable section of society

The principle of local contribution was paramount and was applied with ruthless effectiveness by the Treasury, which clearly did not understand the circumstances within in the Highlands of poverty, lack of employment and in some areas, few cash incomes, and the relentless pressure on the rates. The ambiguities of the poor law principles, sitting side by side with the new social welfare reforms were encompassed within the HIMS, self-help and government intervention, with no means testing. In 1948 William Beveridge wrote *Voluntary Action*, acclaiming the voluntary sector at a time when the state was significantly increasing its role. The state was required, through its own actions, to forge a course between national and local provision, with the ‘weight assigned to statutory and voluntary agencies’.<sup>12</sup>

The NHS provided a comprehensive medical service with universal access and which was free at the point of entry.<sup>13</sup> It represented a final break with the Poor Law philosophies of individual freedom and self-help and can be seen as finalising the changes started with the Liberal welfare reforms at the beginning of the century. It was a tripartite structure comprising hospitals and specialists under fourteen regional boards, general practice under a national contract, and community health services, such as home nurses, midwives, health visitors, maternal and child care, and prevention, under the control of local governments. The HIMS provided more limited centrally organised medical provision but was not free to all.

Without external assistance most people in the Highlands throughout the period under examination were too poor to pay doctors’ fees. The issues surrounding the provision of medical and nursing services in remote areas can be mitigated by greater resources, improvements in communication, experienced general practitioners and trained nurses and an air ambulance system. They are not confined to the Highlands and Islands and the same issues have been experienced in other remote areas, including North America, Australasia and Scandinavia. However, the difficulties of encouraging medical practitioners to move to remote areas cannot all be removed by those improvements. The difficulties of providing medical services in remote and insular areas with inclement weather and topography remain today, illustrated by current difficulties of filling posts in Ardnamurchan, Applecross and the Small Isles.

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<sup>12</sup> Digby & Stewart, ‘Welfare in Context’, in *Gender, Health and Welfare*, pp. 2, 8.

<sup>13</sup> J. Stewart, ‘Ideology and Process in the Creation of the British National Health Service’, *The Journal of Policy History*, 14, 2, 2002.

The factors of remoteness, inclement climate and island communities were and still are obstacles to reaching the sick and also in encouraging doctors to move to Highland practices. Doctors in remote areas require greater 'medical initiative and self-reliance' than in more populated areas, where specialised services are more readily available.

This thesis has demonstrated that while the HIMS was unique in providing medical services to all for a minimum fee, it was not an unmitigated success. It was however an important factor in the development of the National Health Service in Scotland and facilitated amendments to the structure when the tri-partite model was not successful in some rural areas. A clear conclusion is that regardless of the processes which are put in place, any system for the provision of medical services in rural and remote areas will be affected by the difficulties of access and the challenges of attracting professionals to those areas.

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## APPENDIX 1

### CAN THIS BE THE LAND?

Accompanying the increasing trend towards a more sympathetic view of the Highlands was the development of a parallel perception of Highland society as a tragic nation, living in a land of sublime beauty, a perception engendered by visual depictions contained in art and contemporary antiquarian publications. The failure of the Jacobite cause endured in the physical ruins of battle which were scattered throughout the Highlands. The very presence of those ruins both romanticised the past and further diminished the memory of the threat which had been posed by the Jacobites. 'The more the mortar of Invergarry and its counterparts crumbled and fell, the more the spectre of Jacobitism as a cohesive political threat faded from the minds of the British public'.<sup>1</sup> The exaltation of the tragic glory of the Highlands is illustrated in a contemporary poem, *Can This Be The Land?*<sup>2</sup>

#### CAN THIS BE THE LAND?

"How are the mighty fallen!"

Can this be the land where of old heroes flourished?  
Can this be the land of the sons of the blast?  
Gloom-wrapt as a monarch whose greatness hath perished,  
Its beauty of loneliness speaks of the past:—  
Tell me ye green valleys, dark glens, and blue mountains,  
Where now are the mighty that round ye did dwell?  
Ye wild-sweeping torrents, and woe-sounding fountains,  
Say, is it their spirits that wail in your swell?

Oft, oft have ye leaped when your children of battle,  
With war-bearing footsteps rushed down your dark crests;  
Oft, oft have ye thundered with far-rolling rattle,  
The echoes of slogans that burst from their breasts:—  
Wild music of cataracts peals in their gladness,—  
Hoarse tempests still shriek to the clouds lightning-fired,—  
Dark shadows of glory departed, in sadness  
Still linger o'er ruins where dwelt the inspired.

The voice of the silence for ever is breaking  
Around the lone heaths of the glory-sung braves;  
Dim ghosts haunt in sorrow, a land all forsaken,  
And pour their mist tears o'er the heather-swept graves:—  
Can this be the land of the thunder-toned numbers  
That snowy bards sung in the fire of their bloom?  
Deserted and blasted, in death's silent slumbers,  
It glooms o'er my soul like the wreck of a tomb.

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<sup>1</sup> A. Macleod, *The Highland Landscape: Visual Depictions, 1760-1883*, in Eds. D. Broun and M. MacGregor, *Miurun Mòr nan Gall, 'The Great Ill-Will of the Lowlander'? Lowland Perceptions of the Highlands, Medieval and Modern*. p.144, 148.

<sup>2</sup> The Project Gutenberg EBook of *The Celtic Magazine*, Vol. 1, No. 3, January 1876, by Various. 'Can this be the Land?', Wm. Allan, Sunderland, p.87.  
<http://www.gutenberg.org/files/29969/29969-h/29969-h.htm>, accessed 7 August 2010.

## **APPENDIX 2**

### **DEWAR COMMITTEE BIOGRAPHICAL DETAILS**

#### **1. Sir John Dewar, MP for Inverness-shire**

Born in Perth in 1856, Sir John Dewar lived in the family home at Dupplin Castle and was educated at Perth Academy. From 1893-99, prior to his parliamentary career, he was Lord Provost of Perth and was Member of Parliament for Inverness-shire from 1900 until he was created Baron Forteviot in 1916. He was also a Justice of the Peace and Deputy Lieutenant for Perthshire, was Chairman of the distilling firm John Dewar and Sons and a Director of both Buchanan-Dewar Ltd and Distillers Co Ltd. As well as chairing the Medical Services Committee in 1912, he subsequently chaired the Highlands and Islands (Medical Services ) Board from 1913-19 and was an committed supporter of the Small Holder's Bill. He died in 1929.

#### **2. Dr W. Leslie MacKenzie, Medical member for the Local Government Board for Scotland.**

Dr MacKenzie, one of the medical specialists, and one of the most prominent of those represented on the Committee, was born in Shandwick Mains in Ross in 1862. He was educated at the Old Grammar School in Aberdeen, and gained an M.A., from Aberdeen in 1883. He was a distinguished scholar and his other qualifications included M.B., C.M. 1888 (Hons.); D.P.H. 1890; Medico-psychological certificate, 1890 and M.D. 1895 (highest Honours). In addition to his formal qualifications, he won the Bain gold medal and prize, the Hutton prize, and he was the Ferguson Scholar in Philosophy in 1884.

MacKenzie was County Medical Officer of Health for Kirkcudbright and Wigtown from 1891 to 1894 and then Medical Officer of Health in Leith in the period 1894-1901. He gained added prominence in medical circles when he was appointed as the first medical member of the Local Government Board for Scotland in 1901, a post he held for fifteen years, from 1904 to 1919. In that year he received a knighthood. He continued as medical member of Scottish Board of Health till 1928. He was a member of the Royal Commission on Housing (Scotland) receiving a knighthood in 1919 in recognition of his services and was a Crown Nominee for Scotland on the General Medical Council in 1922. He retired from the Civil Service in 1928, but retained his interest in medical matters. In 1929 he was an Honorary Trustee for the Kentucky Frontier Nursing Service, having visited the Service during its development in an advisory capacity and was President of the Royal Scottish Geographical Association from

1931 to 1932. His published works reflected his main professional interests, including 'The Medical Inspection of Schoolchildren' and 'Health of the School Child'. He died in 1935.<sup>1</sup>

### **3. Dr. John Christie McVail, Deputy Chairman of the National Health Insurance Commission for Scotland**

Dr McVail was another well-known figure in medical circles. He was born in Kilmarnock in 1849, and was educated at Anderson's College and Glasgow University. His qualifications, gained over a period of about fifteen years, included L.L.D., Glasgow, M.D., St. Andrews, F.R.F.P.S., D.P.H.(Cambridge.) and D.P.H.F.P.S.(Glasgow). In addition, in 1922, he was the Jenner Medallist for the Royal Society of Medicine, and won the Stewart prize of the British Medical Association.

He had substantial experience as a practising general practitioner and public health medical officer. A period as a general practitioner in his home town of Kilmarnock from 1873 to 1891 was followed by a period of employment as physician to the Infirmary, and a period as Medical Officer of Health and Crown Examiner in medico-legal cases for North Ayrshire. He also served as County Medical Officer for Stirlingshire and Dunbartonshire. His considerable experience and increasing reputation in medical circles led to positions of greater responsibility. He was a member of the Scottish Board of Health, Deputy Chairman of the National Health Insurance Commission for Scotland and Crown member for Scotland of the General Medical Council for the years 1912 to 1922.

As well as his official duties he was an examiner in Medical Jurisprudence and Public Health, at the Universities of Edinburgh, Glasgow and St. Andrews and was ex-president of the Society of Medical Officers of Health of Great Britain and the Incorporated Sanitary Association of Scotland. and of the Glasgow and West of Scotland branch of the British Medical Association. He was also a member of the Court of Governors of the London School of Hygiene and Tropical medicine.

McVail also served on many Governmental enquiries and commissions. He was Medical Investigator for the Royal Commission on the Poor Laws in 1907 and was a member of the Highlands and Islands Medical Service Board from 1913 to 1919. He had an 'opposing political outlook' to MacKenzie, valuing 'personality and independence' above all else. Despite this he and MacKenzie were said to have mutual respect for each other and often

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<sup>1</sup> *Who was Who, 1929-1940; The Medical Directory, 1922; Levitt I., Poverty and Welfare in Scotland, Edinburgh, 1988 and 'The State, family and the Scottish health problem, the work of Dr Leslie MacKenzie, 1891-1928' in Northern Scotland, 17, 1997, pp.55-72.; Katherine, Duchess of Argyll, Working Partnership, pp.6-7.*

'indulged in...friendly argument.' His publications included numerous writings on public health subjects, particularly on smallpox and vaccination. He died in 1926.<sup>2</sup>

#### **4. Dr. Alex Cameron Miller, GP in Argyll**

Dr. Miller was a doctor with wide-ranging experience of general practice in the Highlands. Born in Fort William in 1861, he graduated in 1883 from Edinburgh University with the degrees of M.B. and C.M. and in 1888 gained the degree of M.D with highest honours, again from Edinburgh. His doctoral thesis was entitled 'Insanity and the neurosis' and his publications were wide-ranging. They included 'Maternal and child welfare in a Highland district' in the Carnegie Report of 1917 (Scotland), 'Ben-Nevis catarrh' in the *British Medical Journal* in 1895 and 'Medical work on a Highland railway' in the *Caledonian Medical Journal* in 1895. His scholarly work included translations from French, German and Italian journals.

He was employed as Medical Officer and Vaccinator for the parishes of Kilmallie, Ardgour and Kilmonivaig, and was Medical Officer of Health for Ardgour and Kingairloch, Fort William Burgh and Killmallie district. He was Consultant Physician for Inverness-shire Sanatorium and Surgeon at Belfort Hospital, Fort William. His duties also included a spell as Army Recruitment Medical Officer and Medical Referee under the Workmen's Compensation Act and the Teachers Superannuation Act.

He was a Fellow of the Royal Society of Edinburgh, a Fellow of the Society of Antiquaries, Scotland and was a former President of the Caledonian Medical Association. He was a member of the Scottish Board of Health's Consultative Council on the Highlands and Islands and was Convenor of the Highlands and Islands Committee of the Scottish Medical Insurance Council. His knowledge of the Highlands was extensive, both at the local and regional level and was a Gaelic speaker.

As well as being a practising G.P. he performed many non-medical roles. He was a Justice of the Peace for Inverness-shire, and was Honorary Sheriff Substitute for Argyll, Inverness and Elgin and Nairn. He was also a Justice of the Peace and a freemason. He was also Lieutenant Colonel of the Royal Army Medical Corp. He died on 31st Dec 1927.<sup>3</sup>

#### **5. Katherine, Marchioness of Tullibardine (Duchess of Atholl from 1917)**

The aristocracy was represented by Katherine, the Marchioness of Tullibardine J.P., later Duchess of Atholl. She was born in 1874, and educated at Wimbledon High School and the Royal College of Music. She was a prominent citizen, collecting honorary degrees from

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<sup>2</sup> *Who was Who*, 1916-1928, *The Medical Directory*, 1922, Katherine-Duchess of Argyll, *Working Partnership*, London, 1958, p.6.

<sup>3</sup> *The Medical Directory*, 1922, p.1453; *Caledonian Medical Journal*, Spring 1928.

Oxford, Glasgow, Manchester, Leeds, Durham and McGill and Colombia universities. In 1899 she married the Marquis of Tullibardine, son of the Duke of Atholl and Grand Master Mason of Scotland from 1908-13 ( he succeeded as Duke of Atholl in 1917).<sup>4</sup>

The Marchioness was invited to be a member of the Dewar Committee in 1912, a position she valued, 'I felt very much honoured' and was subsequently a member of the Highlands and Islands Medical Service Board.<sup>5</sup> She also chaired the Medical Service's Consultative Council on the Highlands and Islands from 1920 to 1924. She was a member of Perthshire Education Authority from 1919 to 1924, sat on the Central Agricultural Wages Committee for Scotland from 1918 to 1920 and was also a member of the Royal Commission on the Civil Service from 1929 to 1931. It has been estimated that by 1920 she sat on 25 committees, 12 of which were education committees; she was also President of the Perthshire Federation of District Nursing Associations.<sup>6</sup>

She was considered eccentric by many in her promotion of the rights of the travelling people on the Departmental Committee on Scottish Tinkers in 1917 and 1918 but on some issues she was staunchly traditionalist. She attended anti-suffragette meetings in Glasgow in 1913, believing that women needed more experience in local government before they got the parliamentary vote. She subsequently became the first Scottish woman Member of Parliament and sat as Conservative candidate for the Kinross and Western division of Perth from 1923 till she resigned in 1938. She contested the by-election as an Independent, but was defeated by the Conservative candidate.<sup>7</sup>

## **6. James Cullen Grierson, Convenor of the County of Shetland**

James Grierson, was born in Lerwick in 1863, the son of Andrew J. Grierson of Quendale.<sup>8</sup> His brother was Herbert J.C. Grierson, Professor of English Literature at Aberdeen. He was educated at the Anderson Institute in Lerwick and at Merchiston College. He served an apprenticeship with Lerwick solicitors, Duncan and Galloway, and subsequently with J. and A. Peddie & Ivory W.S. in Edinburgh, qualifying as a solicitor in 1886 at the University of Edinburgh. He returned to Lerwick to start his own legal practice, which in 1895 was amalgamated with that of Alexander Bain.

His obituary noted that he 'had an intimate, almost unsurpassed knowledge of local conditions all over the country'. Grierson was clearly a well-respected figure; during the Crofters Commission fair rent enquiries in 1889, both landlords and crofters employed him as their

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<sup>4</sup> S.J. Hetherington, *Katherine Atholl: against the Tide*, Aberdeen, 1989.

<sup>5</sup> *Working Partnership*, p.66.

<sup>6</sup> *Katherine Atholl: Against the Tide*, p.86.

<sup>7</sup> *Working Partnership*, London, p.66.

<sup>8</sup> I am very grateful to Mr. Brian Smith, Archivist of the Shetland Archives, who provided the bulk of the information on J C Grierson; *Who was Who*, 1929-1940.



agent. 'The son of one of the old Shetland proprietors, and a proprietor himself, he had peculiar opportunities for studying crofting problems'. He was an obvious representative for the Northern Isles on the Dewar Committee.

Well respected in the community, he was a Unionist agent for several parliamentary candidates from 1895. Although a staunch Tory, he was said to be extremely broad-minded in his political relationships and maintained good relationships with other local political parties; for example, a room was made available by him for the meetings of the local socialists. Following a long period as councillor for Sandness and later Aithsting, followed by Vice-Convenor of the first County Council, he was appointed as Convenor for the County. A colleague stated that he 'filled that office with dignity, tact and conspicuous ability' and possessed 'an urbanity of manner gathered from generations'. As well as his public duties he was a keen military man. His involvement included being an enthusiastic member of the First Zetland Rifles and Captain of the Shetland companies of the Gordon Highlanders. He was Captain in the seventh V.B.G.H. in Lerwick during and after the African War and was sub-lieutenant in the R.N.V.R. during the Great War.

Given the tributes paid to Grierson's character and personality, the circumstances of his death, by suicide, were especially tragic. In July 1915 he shot himself in the head at his home at Helendale, outside Lerwick. Local tradition attributed it to some misdemeanour in his legal work, or more spectacularly, that he was a German spy and was discovered signalling to the enemy. However, a more reliable source has stated that he was suffering from a growing drink-related problem and having been given a commission with responsibility for a large vessel, he went off to Symbister, with two cases of whisky and stayed there at a relative's house for a week. On his return he was faced with a proposal to court-martial him for dereliction of duty. However, it is a measure of his popularity and respected position in the community that he was given a full naval funeral, with his naval hat displayed on top of the coffin.

## **7. Dr John L. Robertson, Senior Chief Inspector of Schools for Scotland**

Dr Robertson, born in 1854, was Senior Chief Inspector of Schools for Scotland. Educated at the General Assembly School in Stornoway, he attended Edinburgh University without attending secondary school. He graduated as Master of Arts after three years and later Batchelor of Laws, joining the inspectorate of schools. In 1888 he was appointed as acting Chief Inspector of Schools, a position he later succeeded to. In 1912 he was given an Honorary LL.D. by Edinburgh University and in 1919 he was awarded a C.B. As well as the Dewar Committee he served on Lord Pentland's Committee for the employment of Highland

boys and girls and on the Craik Commission on teachers' salaries. Sir Henry Craik, M.P., considered him to be 'a landmark in the educational history of Scotland'.<sup>9</sup>

When he died in Inverness, six years after his retirement from the post, his popularity was clear in the extent of the activity surrounding his funeral. When his body was returned to Lewis the flags on the island were at half-mast and all businesses were closed at noon. All schools throughout Lewis were closed and 'the senior boys of Nicholson Institute headed the funeral procession, which included the Lewis Pipe Band, the Brethren of the Masonic Lodge, the Provost, Magistrates and Councillors of Stornoway and members and officials of all the other public bodies'. In addition, 'there was a very large and representative attendance of the general public, including people from all parts of the island'. Sir George Macdonald, the Secretary of the Scottish Education Department, extolled his virtues and said 'Few men in our time have laid their native country under so deep an obligation as he has done'.<sup>10</sup>

#### **8. Andrew Lindsay D.L., J.P., Convenor of the County of Sutherland**

Andrew Lindsay, born in 1848, was an ironmonger and County Councillor for Golspie and then Rogart. Described in his obituary as 'the uncrowned king of Sutherland' he ran his 'flourishing business', was Convenor of the County of Sutherland, Chairman of School Boards and the Education Committee, the Insurance Committee and the Liberal Association. He was also Sabbath School Superintendent and 'preacher of the everlasting gospel'. He was a staunch Liberal but refused to stand for election as an M.P. He appeared to view some politicians with some caution, referring to those who benefited financially from politics as 'tide-waiters'. In 1910 during the general election campaign, he was reported to have declared at an election meeting 'that they were fighting for freedom and opposing the hereditary principle here on their doorstep in Sutherland; he claimed that the Duke had become "the victim of a pernicious system, which was the embodiment of Toryism" and that the Duchess, having taken to the political platform, "must simply take what was going"'. On his retirement he was offered and turned down a knighthood. He died on 9 November, 1934, in Golspie aged 86.<sup>11</sup>

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<sup>9</sup> 'Noted Educationalist, Late Dr J.L. Robertson', *The Scotsman*, 13 June 1927, p.8. I am grateful to Dr Kenneth Baxter for locating those articles.

<sup>10</sup> 'Late Dr J.L. Robertson', Sir George Macdonald's tribute, *The Scotsman*, 16 June 1927, p.8.

<sup>11</sup> Notice of death and Obituary, *Northern Times and Weekly Journal for Sutherland and the North*, November 15, 1934; G Baggott, 'Melness Farm, Sutherland: The Land Question and the Congested Districts Board, c.1866-1911, in *Journal of Scottish Historical Studies* 30.1, 2010, p.10; <http://archiver.rootsweb.ancestry.com/th/read/SCT-SUTHERLAND/2003-08/1060378255> (accessed April 2011)

## 9. Charles Orrock, Chamberlain of Lewis

The final member of the committee was Charles Orrock, an accountant, born in 1856 at Cockpen, Dalkieth.<sup>12</sup> He moved to Stornoway in 1876 to take up the position of senior clerk/assistant factor in the Lewis Estate Office, previously having been at Mssrs. Innes & Mackay, Inverness. His wife and Mother in Law were from Barvas on Lewis and all spoke Gaelic and English, which enabled him to fit into life in the islands. 'One of the great secrets of his success was his untiring industry, his indefatigable spirit for work. His knowledge of Gaelic, exceptionally useful to his office, enabled him to enter fully and appreciatively into the...points of view of crofters and cottars.' Outside of the Islands he was viewed as an expert on Highland matters, which would have benefitted his work on the Dewar Committee.

In July 1891 he was elected to Uig School Board, in September 1891 the Barvas School Board and November 1891 the Lochs School board. The only Lewis school board he wasn't on was Stornoway's (no evidence as to why) but his obituary makes reference to his interest in youth in rural communities. He chaired these boards for many years right up until their abolition in 1919. He does not appear on the new Lewis School Management Committee that took over. In 1892, he became Chamberlain of Lewis, a position he retained until his death in 1920. That year he was also elected a Stornoway Pier & Harbour Commissioner, staying in post until his death in 1920, at one time being Vice Chair under Lord Leverhume's chair.

His period as Chamberlain saw the passing of the Island's ownership from the Matheson's to Leverhume. As Chamberlain he oversaw precarious and troublesome times of crofter agitation in Lewis. Clearly a popular man, he held the 'esteem of the Estate and trust and entire good-will of the crofting community'. 'His appointment in 1892 was regarded by Estate and Crofters alike as necessary to stabilise a tender situation.'

Having had excellent health he died at 65 during an epidemic; his daughter, Mary, also died within a week. Lord Leverhume, who was in transit between Liverpool and America on the Aquitania telegraphed Mrs Orrock 'Sincerest sympathy on death of your husband. Hope your daughter out of danger'. Mr Orrock's funeral at Sandwick Cemetery was the largest seen for many years on the island. His daughter's funeral the follow week was even larger.<sup>13</sup>

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<sup>12</sup> I am grateful to David Powell, Archivist of Comhairle nan Eilean Siar, for this biographical information from the *Stornoway Gazette*, 26 November 1920. A further article in the same edition of the *Gazette* discusses the funerals of Orrock and his daughter.

<sup>13</sup> The chamberlain acted as treasurer, receiving the rents and fees of the area of jurisdiction; <http://boards.ancestry.co.uk/surnames.orrock/1/mb.ashx>; He was clearly a popular man, the local butcher in Stornoway gave his son, born in 1920, the year of Orrock's death, the middle name, Orrock. *The Monthly Record*, Nov 2006 (Magazine of the Free Church).

## 10. Murdoch Beaton

Murdoch Beaton, the secretary of the Dewar enquiry, was born in 1869 in Ardelve, Lochalsh. The son of an elder of the Free Church he was a graduate of Aberdeen University, during which time he was a member of the Highland Land League. Formerly a teacher at the public school in Golspie and Wallace Hall Academy, Dumfries, he then became an Inspector of Schools covering the Outer Isles. He visited St Kilda in 1905-7. Later, during the period of the enquiry, he was an Inspector under the National Health Insurance Commission (Scotland). He was appointed as Secretary of the Dewar Committee in 1912; his assistant on the committee was Miss Tolmie, about whom little is known.<sup>14</sup>

At the outbreak of war he joined his regiment, the 4<sup>th</sup> Cameron Highlanders and served as Captain. In 1915 he was reported as being still 'in the trenches'.<sup>15</sup> He was promoted to temporary major and eventually Lieutenant Colonel, commanding the 4<sup>th</sup> battalion of the Queen's Own Cameron Highlanders. Following the war he worked for the Poor Law Commission and was involved in the evacuation of St Kilda in 1930. He died in 1948 in Edinburgh.

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<sup>14</sup> I am grateful to Dr Miles Mack, GP in Dingwall, and Iain Beaton, Murdoch Beaton's grandson, for information on Murdoch Beaton, following their meeting in, Uig, Skye. Note: the *BMJ* refer to him as Malcolm Beaton, 11 Sept 1915, p.402.

<sup>15</sup> *The Scotsman*, 16 August 1915.

## APPENDIX 3

### APPENDIX No. 4

Return no 1

#### RETURN OF INFORMATION FROM MEDICAL PRACTITIONERS

- |   |   |  |
|---|---|--|
| <p>1. Name and Address of Practitioner. Medical School and Degrees or Qualifications.</p> <p>2. (a) Experience previous to entering on present practice.<br/>(b) How long engaged in present practice?</p> <p>3. The area within which your practice is ordinarily conducted. Please make outline thereof on enclosed map, and indicate the position of<br/>(a) Your own residence by a circle O.<br/>(b) Nurse's residence by a square xx<br/>(c) Hospital by a cross xx<br/>(d) Sanatorium by a triangle xx</p> <p>4. Name of any doctor or doctors ordinarily practising wholly or partially in the same area. If partially, within what part of the area.</p> <p>5. The approximate population of the area of your practice. (the census population, 1911 of the parish of was ).</p> <p>6. (a) Names of towns, village~ and townships.<br/>(b) Approximate population of each.<br/>(c) Distance in miles of each from your residence.</p> <p>7. (a) Distance of Doctor's residence from more remote homesteads. How are these reached ?<br/>(b) What is the proportion of patients at five, ten, and twenty miles?</p> <p>8. Description of-<br/>(a) Roads as to surface, gradient, and suitability for wheel traffic.<br/>(b) Paths - whether foot or bridle paths or both.<br/>(c) Ferries and Fords - how crossed - whether dangerous or not.</p> <p>9. Means of travel and cost thereof (e.g., motor car, motor cycle, bicycle, horse carriage, riding horse boat), privately and by hire.</p> <p>10. Doctor's residence. By whom provided. Rent. Rates. Sufficiency or insufficiency of accommodation. General suitability.</p> | <p>11. (a) Doctor's public appointments, with conditions of and emoluments from each.<br/>(b) Observations as to security or insecurity of tenure of Parish Council appointment.</p> <p>12. Could you undertake the work of additional appointments ?</p> <p>13. Are vaccinations charged separately?</p> <p>14. Does the Parish Council fix special days for vaccination?</p> <p>15. Number of Paupers.</p> <p>16. (a) Description of any local Club or similar system of payment for medical attendance, with any critical remarks on such system.<br/>(b) If Club, payment is partly by the proprietor and partly by the tenant, does the latter usually pay?<br/>(c) On the alternative schemes of payment per attendance and payment under Club arrangement with modified fees per visit, do you find a readiness to pay ?<br/>(d) In your experience of crofting and fishing communities, do you think a Club arrangement or payment by visit preferable, or a combination of both?</p> <p>17. Medicine-<br/>(a) How supplied.<br/>(b) If you supply medicine, do you charge for it separately ?<br/>(c) Do you readily obtain supplies of fresh drugs ?</p> <p>18. Main sources of livelihood of the population.</p> <p>19. Classes of people included in your practice.</p> <p>20. Average ability to pay fees for medical attendance.</p> <p>21. What is your ordinary visiting fee, calculated by mileage and time?</p> <p>22. (a) Estimate of proportion of cases of illness among poor (non-pauper) people not medically attended.<br/>(b) General causes of non-attendance.</p> <p>23. What are your arrangements for dealing with serious surgical, medical, and maternity cases?</p> <p>24. (1) Average number of confinements annually.<br/>(a) Number attended by Doctor.<br/>(b) Number attended by Certificated or Maternity Nurses only.<br/>(c) Number attended by Uncertificated Nurses only.</p> | <p>(2) Note of any deaths or evil results from want of proper attendance in confinement in the case of -<br/>(a) Mothers.<br/>(b) Infants.<br/>(3) What is your fee for confinements?</p> <p>25. Is there much tuberculosis disease, either pulmonary or non-pulmonary, in your practice?</p> <p>26. If you do not object, will you kindly indicate the gross amount of your income from all sources, and your net income after deducting expenses and such items as house rent?</p> <p>27. Supply of Nurses-<br/>(1) Number (a) Certified.<br/>(b) Uncertified.<br/>(2) Amount and source of their remuneration.<br/>(3) Sufficiency or insufficiency of nursing service.<br/>(4) To what extent do you avail yourself of such assistance?<br/>(5) Do the Nurses work directly under your control?<br/>(6) Do they nurse infectious cases? think may be of use to the Committee.</p> <p>28. Facilities for hospital treatment.</p> <p>29. Changes, if any, of Doctors in the district during, say, the past ten years. Reasons therefor.</p> <p>30. Do you think it would be advantageous to the profession and the public to have a central, authority to whom questions affecting medical service might be referred?</p> <p>31. What holidays do you get, and, how is your work done and paid for in your absence?</p> <p>32. Other information which you think may be of use to the Committee.</p> <p>33. Adequacy or inadequacy of medical and nursing provision in the district.</p> <p>34. General suggestions as to improvement of the medical service in the Highlands and Islands.</p> |
|---|---|--|

Return No. 2.

#### RETURN OF INFORMATION FROM NON-MEDICAL WITNESSES

- |  |   |   |
|--|---|---|
| <p>1. Name, Address, and Occupation of Witness.</p> <p>2. Main sources of livelihood of the people.</p> <p>3. Average ability to pay Doctor's fees</p> | <p>6. Changes, if any, of Doctors during, say, the past ten years, with reasons therefor.</p> <p>7. Hospital provision.<br/>How financed.</p> <p>8. Estimate of proportion of cases</p> | <p>10. Supply of Nurses-<br/>Amount and source of their remuneration.<br/>Their value.</p> <p>11. Further relative information.</p> |
|--|---|---|

4. Description of Club or similar system of medical payment. How far satisfactory.	of illness among poor (nonpauper) people not medically attended. Probable explanation.	12. Adequacy or inadequacy of medical and nursing provision in the district.
5. Supply of Medicine.	9. Give one or two instances of difficulty or failure in obtaining medical attendance.	13. General suggestions as to the improvement of medical service in the Highlands and Islands.

## COVERING LETTER

### HIGHLANDS AND ISLANDS MEDICAL COMMITTEE

### INVERNESS

DEAR SIR;:-As you are probably aware, a Committee has been appointed to consider how far the provision of medical attendance in districts situated in the Highlands and Islands of Scotland is inadequate, and to advise as to the best method of securing a satisfactory medical service therein, regard being had to the duties and responsibilities of the several public authorities operating in such districts. I have accordingly been instructed by the Committee to say that they would esteem it a great favour if you would assist them in the enquiry, and if you could find it convenient to send them concise note of the conditions as to medical attendance in your district, appending a statement of your opinion generally as to the best means of improving the existing medical service in the Highlands and Islands. It has occurred to the Committee that the information

might be more conveniently and systematically supplied by means of answers to the enclosed set of queries. Answers to queries to which you have any objection are not, of course, expected, but the Committee trust you will see the importance of aiding them in the collection of a large body of fact and advice on which to base conclusions and recommendations. I need hardly add that any statement which you wish to be regarded as confidential will be so treated. It will be an additional favour if you reply early and if possible, by the prox.

Yours faithfully,

M. BEATON  
*Secretary.*

**Source: Highlands and Islands Medical Service Committee, Report to the Commissioners of His Majesty's Treasury, Volume I, 1912, Cd. 6559, pp.52-53.**

## APPENDIX 4

### CIRCULAR LETTER, SENT BY BOARD TO LOCALITIES, 15 JANUARY 1914

Sir,

1. I am directed to state that the Board have had under consideration the Sections of the Highlands and Islands (Medical Service) Grant Act of 1913, which provide for the administration of the Fund created by that Act.

2. The Act provides for subsidies from the Fund being placed at the disposal of Local Authorities, Insurance Committees, District Nursing Association, or other bodies or persons, or of any joint committee of Local Authorities or Insurance Committees or of Local Authorities and Insurance Committees.

Local Authorities are defined as County Councils and any authority under the Public Health (Scotland) Act, 1897, and Parish Councils, School Boards, and Secondary Education Committees,

The Act further provides that Local Authorities and Insurance Committees shall have power to appoint joint committees for the purpose of this Act.

It is clear that the intention of the Act is to provide for a development and correlation of the existing public services so far as that can be effected by combination amongst the bodies concerned. The Board, therefore, regard it as an important part of their work to bring about an administrative consolidation of the existing services, and no payment will be made from the Fund except as part of a well-considered scheme in which all of the existing services can be turned to the best account.

3. It is of the first importance that all statutory bodies concerned should realise that the improved service provided for by the Act is not intended to relieve them of their existing obligations in regard to medical service. On the contrary, it should, in the opinion of the Board, be a condition precedent to any grant from the Fund that the bodies in question are taking reasonably full advantage of their powers under the statutes in force.

4. It will be observed that the administration and application of the Fund must be in accordance with a scheme or schemes prepared by the Board and approved by the Secretary for Scotland with the consent of the Treasury. The Board propose to proceed forthwith with the preparation of such schemes; but they feel that the needs of the several districts vary so much in character and extent that it would be impossible to frame satisfactory schemes for the application of the Fund without first obtaining the views of the bodies who, as provided in the Act, may be entrusted with, or associated in, the administration of grants from the Board.

5. I am, accordingly, to ask the co-operation of the various authorities concerned. A statement of their experience, in so far as they have had difficulties to contend with in the provision, the supervision, or the administration of any form of medical service, including nursing, in their respective areas, would be of the utmost value to the Board. It would facilitate consideration of definite proposals if any statement that it may be desired to submit were made in the form of answers to the queries set forth on the accompanying schedule. But any suggestions in regard to points not covered by these queries will also receive the fullest attention.

6. In connection with the preparation of schemes the Board, subject to the consideration of any alternative proposals that may be submitted, have at present in view the following:-

## **A. MEDICAL ATTENDANCE**

(a) The Board must satisfy themselves as to the extent and adequacy of the Medical Attendance, including nursing, hospitals, ambulance, and other specialised medical and pathological work provided under the various statutory public services-Poor Law, Vaccination, Old Age Pensions, Public Health, National Insurance, Medical Inspection and Treatment of School Children, etc.

(b) The Board will also consider by what methods the cost of medical attendance other than that provided or assisted through public funds - local or imperial - can best be brought within the means of persons of only very limited income. In particular, it is felt that the fact that a patient's residence happens to be distant from the nearest doctor ought not to add to the cost.

To facilitate communication with the doctor, it will be the aim of the Board to take advantage of telephone and telegraph services wherever these exist, and to get extensions of these services, introduced where practicable. To facilitate attendance at patient's residences, it will frequently be essential that the doctor be enabled to provide, or be provided with, the most suitable means of conveyance-motor car, motor cycle, motor boat, a horse for bridle paths, and so forth, according to circumstances. In some cases, it will probably be necessary to provide a doctor with a suitable dwelling-house so that his work may be carried on from a centre convenient to the population depending upon him for attendance. As indicated in the Report<sup>#</sup> of the Highlands and Islands (Medical Service) Committee, there is abundant evidence that the income of many of the doctors in the Highlands and Islands is entirely inadequate for the services required of them. This should be kept in view in any suggestions that it may be desired to submit.

## **B. NURSING**

With a view to securing that every area shall have an adequate nursing service it is proposed to see that, in one way or another, nurses are established at convenient centres throughout the Highlands and Islands. It will be the endeavour of the Board to utilise the local nursing associations, where these exist, but in any case the system of nursing to be organised must be such as to meet the requirements both of the official and of the voluntary medical services so far as that may be found practicable. The qualifications required of the nurses will vary with the circumstances, and the variation will largely depend on the practicability of close supervision of the work of the nurse or nurses by the medical practitioner of the locality. The duties of the nurses will be related alike to medical, surgical, and midwifery cases. In many instances, perhaps in most, the headquarters of a nurse ought to be at the hospital of her district as referred to under the following heading.

## **C. HOSPITALS**

In some districts there is need for small hospitals capable of accommodating four to six patients. Due regard must of course be paid to existing accommodation, but the main consideration determining the situation of these hospitals will be their accessibility to the population to be served, and the convenience of medical and nursing attendance. They will naturally be of simple structure and will include accommodation for a small resident staff of, say, one nurse and a maid servant. Such hospitals might be used for cases where house accommodation for domestic nursing is unsuitable, and for cases where medical attendance can be better given at the hospital than at the patient's home. Where, for example, the patient's home is far distant from the doctor, whilst at the same time the nature of the illness frequent visits, the case may be removed to the hospital for treatment there.



#### **D. SPECIALISED MEDICAL SERVICES**

The Board will also take into consideration the local needs for specialised medical services. Such services include provisions for examination and treatment of eyes, ears, and teeth - particularly of school children,- laboratory facilities, provision of surgical appliances, assistance at operations, medical consultations, etc. In considering the provision, by School Clinics or otherwise, for the medical treatment of school children the Board will have regard to the Imperial funds placed at the disposal of School Board for this purpose.

It is recognised that the schemes outlined above do not exhaust the means that might be employed for the prevention, treatment, and alleviation of illness and suffering, but it is thought that they would go far towards meeting the more pressing needs in the great majority of localities.

7. The Board are of opinion that in very many cases the Fund can be most efficiently and economically applied by means of schemes framed in relation to the needs of areas larger than single parishes, and they accordingly invite proposals from County Councils, District Committees, Secondary Education Committees, Insurance Committees, District Nursing Associations, or any other bodies or persons interested in the administration of the Fund from this point of view. Joint recommendations from the authorities of the larger areas would be particularly valuable wherever a scheme for the combination of such larger areas is regarded as at all practicable. But the Board will welcome any suggestions from Parish Councils and School Boards or any joint accommodation from these authorities in all cases where the parish area is deemed to be the most suitable one as the basis of a scheme for any form of assistance.

8. A copy of this Circular has been addressed to all County Councils, District Committees, Insurance Committees, Secondary Education Committees, District Nursing Associations, District Lunacy Board, Parish Councils, Town Councils, and School Boards, and to all medical practitioners in the area covered by the Act, and I am to suggest that all bodies and persons concerned should take immediate steps by conferring amongst themselves, or otherwise as may be thought expedient, to prepare a statement of what are considered to be the special needs of their districts and the best form in which assistance may be given. The preparation and approval of schemes in terms of Section 1 (2) of the Act must inevitably entail some little delay. As the Board are anxious to proceed at once to administer the Fund, I am to request that any statement that it may be desired to submit may be sent to the Board at the earliest possible date, and in any case not later than the 15th January 1914.

I am, &c.

**Source: First Annual Report of the Highlands and Islands Medical Service Board, Cd.7977, 1914, pp6-9.**

## APPENDIX 5

### MEDICAL WITNESSES TO THE DEWAR ENQUIRY

#### THE COUNTY OF ARGYLL.

CAMPBELL, JOHN Crofter,. Kilmorey, Ardnamurchan  
GILLIES, Dr P. H., Easdale. (*non-oral*)  
GILMOUR, Dr T/F, Portellen, Islay.  
GRANT, Dr LACHLIN, Ballachulish.  
HUNTER, Dr J., Lochgilphead.  
KAY, T., Teacher, Craignish.  
MACALISTER, Mrs, Connel. (*non-oral*)  
MACCALLUM, Rev. MALCOLM (E.C.), Chairman of Lorn District Committee.  
MACDIARMID, H., Farmer, etc., Tiree. (*non-oral*)  
MACGILLIVBAY, F. W., Ardfin, Jura. (*non-oral*)  
MACGBEGOR, A. M., Inspector of Poor, Buessan.  
MACKAY, Dr ARCHIBALD, Appin.  
MACLEAN, D., Factor, Strontian. (*non-oral*)  
MACNAUGHTON, Dr A., Salon, Lochsunart.  
MACNICOL, Dr R. R., Taynuilt.  
MACNIVEN, Rev. J., Kilchoan. (*non-oral*)  
MAORAE, Rev. F., Dalmally. (*non-oral*)  
M\_KECHNIE, Dr ALEX., Buessan.  
M\_NEILL, Dr ROGER, County Medical Officer of Health.  
MORRISON, C. R., Inspector of Poor, Dervaig, Mull.  
PLOWDEN, Mrs, Lochfyneside. (*non-oral*)  
Ross, Dr MACDONALD, Morvern.  
SMITH, Rev. J. (E.C.), Kilchoan.  
STEWART, Dr J., Inverary. (*non-oral*)

#### THE COUNTY OF CAITHNESS.

ASHER, Dr ALEXANDER, Thurso.  
CAIRNIE, D. D., Chemist, Thurso.  
DICK, Dr GEORGE, County Medical Officer of Health and School Medical Officer.  
DUFFUS, Dr J. W., Canisbay.  
DURBAN, Dr D., Thurso.  
GEDDIE, Dr W. S., Halkirk. (*non-oral*)  
KENNEDY, Dr J. R., Dunbeath.  
MACGREGOR, Dr J. G., Castletown.  
MACLENNAN, Dr JOHN, Thurso.  
MEADE, Dr J. N., Lybster.

#### THE COUNTY OF INVERNESS.

BLACKBURN, W., of Roshven. (*non-oral*)  
BRANDER, Dr T. L., Fort-William.  
CAMERON, Rev. A. (E.C.), Sleat, Skye. (*non-oral*)  
CAMERON, Colonel D. W., of Lochiel.  
CAMERON, Rev. H. (R.C.), Barra.  
CAMERON, J.T., Gesto, Skye. (*non-oral*)  
CAMPBELL, Dr A. G. L., Gesto Hospital, Edinbane, Skye.  
CHISHOLM, .ARCKIBALD A., Procurator-Fiscal, Lochmaddy.  
CHISHOLM, The Very Rev. JAMES CANON (R.O.), Arising.  
DE SYLVA, Dr E. J. M., Arisaig.  
DEWAR, D., Chemist, Portree.  
ELLICE, Captain E. C, of Glengarry, Chairman, County Insurance Committee  
FBASER, THOMAS, Factor, Stratherrick. (*non-oral*)  
FLETCHER, Dr DUNCAN, Medical Officer of Health for Skye and Harris, and School Medical Officer.  
GIBSON, ALEXANDER, Inspector of Poor, etc., Arisaig. (*non-oral*)  
GILLIES, REV. EWEN (U.F.C.), North Uist. (*non-oral*)  
GRAHAM, DONALD, Crofter, Rona, Skye. GRANT,  
Rev. ALEXANDER (B.C.), Bernera, Harris. (*non-oral*)  
GRANT, IAN R. M., Glenmoriston.

HASTINGS, Dr W. B., Sleat, Skye. (*non-oral*)  
 JOHNSTONE, Dr D. S., Fort-Augustus.  
 KIRKPATRICK, DAVID, Teacher, Waternish, Skye.  
 LEACH, Dr JOHN, Beaully.  
 LOVAT, THE Rt. Hon. Lord, Vice-Convener of the County.  
 MACAULAY, Dr ANGUS, Benbecula.  
 MACDONALD, Dr A. GRANT, Uig, Skye.  
 MACDONALD, ALEX., Factor, South Uist, (*non-oral*)  
 MACDONALD, Dr DAVID, Glenurquhart.  
 MAODONALD, Rev. D. ALEX. (U.F.C.), Kilmuir, Skye.  
 MACDONALD, Dr DONALD, Laggan.  
 MACDONALD, Dr DONALD JOHN, Carbost, Skye. (*non-oral*)  
 MACDONALD, Hon. GODFREY, Armadale Castle, Skye (*non-oral*)  
 MACDONALD, Dr JOHN, Medical Officer of Health for the County.  
 MACDONALD, Dr LACHLIN, Eigg. (*non-oral*)  
 MACDONALD, J. A. RONALD, of Balranald, North Uist. (*non-oral*),  
 MACDONALD, Dr R. CADELL, Foyers.  
 MACDONALD RONALD, Solicitor, etc., Portree.  
 MACDONALD, Lieut.-Col.\* T. R., Inverness,  
 MACDOUGALL, Rev. A. (R.C.), South Uist.  
 MACDOUGALL, Rev. J. (U.F.O.), Snizort, Skye.  
 MACKAY, Rev. D. (R.C.), Strathglass. (*non-oral*)  
 MACKAY, J. G., Portree.  
 MACKENZIE, Dr F. M., Inverness.  
 MACKENZIE, HECTOR, Factor, North Uist. (*non-oral*)  
 MACKENZIE, JOHN, Factor, Dunvegan. (*non-oral*)  
 MACKENZIE, Dr M. T., North Uist.  
 MACKENZIE, WM., Teachers Valtos, Skye. (*non-oral*)  
 MACKINNON, Dr A. D., Broadford, Skye. (*non-oral*)  
 MACKINNON, JOHN, Crofter, Stocknish, Harris, (*non-oral*)  
 MACKINTOSH, THE Very Rev. ALEX. CANON (R.C.), Fort-William.  
 MACKINTOSH, THE MACKINTOSH OF, Lord Lieutenant, and Convener of the County.  
 MACLEAN, Rev. D. (E.G.), Duirnish, Skye.  
 MACLEAN, NEU., Farmer, Benbecula. (*non-oral*)  
 MACLELLAN, Rev. W. (R.C.) Bornish, South Uist, (*non-oral*)  
 MACLEOD of Macleod, Dunvegan.  
 MACLEOD, Dr M., Tarbert, Harris.  
 MACLEOD, Dr W., Broadford, Skye.  
 MACMILLAN, R. M., Clerk to District Committee, etc., South Uist.  
 MACPHERSON, JOHN, Crofter, Glendale.  
 MALCOLM, GEORGE, Factor and Valuator, Fort-William.  
 MARTIN, Mrs NICOL, Glendale, Skye. (*non-oral*)  
 MACRAE, Rev. ANGUS (R.C.), Morar.  
 MACRAE, JAMES, Inspector of Poor, Glenelg.  
 MACBAE, KENNETH, Sherriff-Clerk, Portree. (*non-oral*)  
 MACTAGGART, Rev. ALEX. (B.C.), Glenelg. (*non-oral*)  
 M\_INTOSH, Dr F. M., Barra. (*non-oral*)  
 M\_INTOSH, F., Inspector of Poor, Laggan.  
 MEIKLE, W., Soay, Skye. (*non-oral*)  
 Moir Dr J. MUNRO, Inverness.  
 M\_NEILL, Rev. J. (R.C.), Eriskay, South Uist.  
 NICHOLSON, A. W., of Arisaig. (*non-oral*)  
 NICOLSON, JOHN, Crofter, Rona, Skye. (*non-oral*)  
 NICOLSON, RONALD, Crofter, Braes, Skye.  
 ORDE, Sir A. CAMPBELL, Bart., of North Uist.  
 REARDON, Dr, South Uist.  
 SHAW, D., Farmer, Flichity, Daviot. (*non-oral*)  
 SMITH, RODERICK, Postmaster, etc., Tarbert, Harris.  
 STEWART, Dr MALCOLM, Portree.  
 STEWART, Dr WILLIAM, Dunvegan.  
 TOLMIE, Dr J. PRINGLE, Harris.  
 WILSON, THOMAS, Sub-commissioner, Lochmaddy.

YOUNG, COLIN, Provost of Fort-William.

#### **THE COUNTY OF ORKNEY.**

BAIKIE, ALFRED, of Tankerness, Convener of the County.

*(non-oral)*

BELL, Dr BENJAMIN, D.C., Kirkwall.

CLOUSTON, R. W., Stromness. *(non-oral)*

DUNCAN, Dr F. J. L., Stromness. *(non-oral)*

GARRIOCH, JOHN, Farmer, Evie.

GIBSON, GEORGE, Farmer, Rousay.

GRANT, Dr, Stromness. *(non-oral)*

GUNN, Dr A. B., M., Westray. *(non-oral)*

HEDDLE, Dr, Medical Officer of Health for the County.

JOHNSTON, J., of Coubister.

LOW, Dr A. L., Stromness.

McNEILL, Dr MARY, Holm.

Mum, WM., Inspector of Poor, Sanday. *(non-oral)*

PARK, Dr W., Sanday.

RICHARDSON, Dr ADAM, Longhope. *(non-oral)*

SINCLAIR, Dr, Kirkwall.

TULLOCH, J., Inspector of Poor, Eday.

#### **THE COUNTY OF PERTH.**

ANDERSON, Dr JOHN, Pitlochry.

DRUMMOND, Rev, GEORGE (E.C.), Glenlyon.

FOTHRINGHAM, W. STEUART, of Murthly, Convener of the County.

GRAHAM, JOHN T., Medical Officer of Health for the County.

HARVEY Dr WILLIAM, Callander. *(non-oral)*

LAMONT, DONALD, Farmer, Invervack, Blair-Atholl. *(non-oral)*

MACKAY, Dr JOHN, Aberfeldy.

NORRIS, Dr S.K., Kinlochrannoch.

ROBERTSON, DONALD, Farmer, Strathtummel.

STIRLING, Hon. Mrs, of Keif, Dunblane.

WILSON, Dr ALEXANDER, Killin. *(non-oral)*

#### **THE COUNTY OF ROSS.**

ADAM, Dr JOHN, Dingwall.

ANDERSON, J. N., Solicitor, Stornoway, Chairman of Lewis District Committee.

BRUCE, Dr W., Medical Officer of Health for the County. BURNS, Mrs Isabella, Lochs, Stornoway.

CALDER, Dr ALEXANDER J. W., Torridon. *(non-oral)*

CAMERON, Dr ALLAN, Lochs.

DUNCAN, Dr GEORGE, Lochalsh. *(non-oral)*

HENDERSON, J. T., Registrar and Chairman of School Board, Ullapool.

HUNTER, ROBERT, Chairman of the Parish Council of Barvas, Lewis. *(non-oral)*

JOHNSTON, Rev. W. (U.F.C.), Shieldaig. *(non-oral)*

KNOX, Dr W. N., Gairloch.

LAWSON, J. W., Shooting Tennant, Achnahaird, Coigach.

LUCAS, Dr C. B., Applecross. *(non-oral)*

MACCALLUM, Rev. D. (E.C.), Lochs. *(non-oral)*

MACDONALD, ANGUS, Teacher, Graver, Lewis, *(non-oral)*

MACDONALD, RONALD, Chairman of the Parish Council of Uig, Lewis.

MACFARLANE, M., Merchant, Cross, Lewis. *(non-oral)*

MACKAY, Dr C. G., Lochcarron.

MACKINNON, KENNETH, Crofter, Balallan, Lewis.

MACIVER, Rev. P. J. (E.C.), Kintail.

MACKENZIE, Rev. ALLAN (E.C.), Uig, Lewis.

MACKENZIE, D., Torridon, Clerk to District Committee, etc.

MACKENZIE, JOHN, Provost of Stornoway.

MACKENZIE, Dr MURDOCH, Stornoway.

MACKENZIE, RODERICK, Clerk to School Board, etc.,  
Garve.

MACKENZIE, Colonel STEWART, of Seaforth.

MACKINTOSH, J., Inspector of Poor, Lochalsh. (*non-oral*)  
 MACLEAN, Dr W., Seaforth Sanatorium.  
 MACLEAN, JOHN, Crofter, Coigach.  
 MACLENNAN, JOHN, Factor, Kishorn. (*non-oral*)  
 MACLEOD, Rev. D. (F.C.), Coigach. (*non-oral*)  
 MACLEOD, G. G., Teacher, Ardgay, Vice-Chairman of the County Insurance Committee.  
 MACLEOD, MALCOLM, Fisherman, Bernera, Lewis.  
 MACRAE, Dr D. J., Lochalsh.  
 MACRAE, JOHN, Farmer, Uig, Lewis.  
 MACRAE, Dr F., Alness. (*non-oral*)  
 MACNAUGHTON, Dr D. G., Poolewe. (*non-oral*)  
 MORRISON, Rev. D. H. (U.F.C.), Barvas, Lewis.  
 MURCHISON, Dr ALEXANDER, Stornoway.  
 MURRAY, CHARLES of Lochcarron.  
 MURRAY, Miss K., Ness, Lewis. (*non-oral*)  
 MURRAY, Dr D., Medical Officer of Health for Lewis District and School Medical Officer.  
 Ross, Dr J. MACDONALD, Barvas, Lewis.  
 Ross, Dr VICTOR, Uig, Lewis.  
 Ross, W. A., Solicitor, Stornoway, Hon. Secretary of Lewis Hospital.  
 SMITH, DONALD, Clerk to Barvas and Lochs Parish Councils, Lewis.  
 SMITH, RODERICK, Chemist, Stornoway.  
 WALLACE, Dr DAVID, Ullapool.

#### **THE COUNTY OF SHETLAND.**

ANDERSON, THOMAS, of Hillswick, Vice-Convener of Shetland.  
 BRUCE, W. A., of Symbister, J.P., D.L., Chairman of Parish Council at Whalsay, Nesting, and Lunnasting.  
 CAMERON, JANE C, Lerwick. (*non-oral*)  
 COCHRANE, Dr JAMES D., Bridge of Walls.  
 FERGUSON, MARY C. B., Matron, Gilbert Bain Hospital, Lerwick.  
 FOTHERINGHAM, REV. WILLIAM (Baptist), Dunrossness.  
 LAING, A. L., Chemist, Provost of Lerwick. (*non-oral*)  
 MACKENZIE, Nurse, Fair Isle.  
 MACLEAN, DONALD, Missionary and Schoolmaster, Fair Isle.  
 ROBERTSON, Dr JOHN F., Lerwick.  
 SANDIESON, C. G. D., Balta Sound.  
 SAXBY, Dr THOMAS E., Unst.  
 TAYLOR, Dr HENRY PEARSON, Mid-Yell.  
 YATES, GEORGE, Crofter, Bressay.

#### **THE COUNTY OF SUTHERLAND.**

BREMNER, Dr A., County Medical Officer of Health and School Medical Officer.  
 COOPER, J. M., Crofter, Rosehall.  
 COWIE, CUTHBERT, Inspector of Poor, etc., Scourie.  
 FRASER, I., Chemist, Helmsdale, Chairman Kildonan Parish Council.  
 GEORGE, DANIEL, Golspie, Treasurer of Sutherland Nursing Association.  
 GORDON, J., Commission Agent, etc., Lochinver. (*non-oral*)  
 GRANT, Dr DUNCAN, Tongue.  
 GUNN, Rev. ADAM (U.F.C.), Chairman of Parish Council of Durness.  
 GUNN, HUGH, Inspector of Poor, etc., Balagill, Farr.  
 GUNN, W., Postmaster, Kinbrace.  
 JAMIESON, Dr CHARLES, Scourie.  
 JOHNSTONE, Dr WALTER E., Brora.  
 JOLLIE, Dr P. OSWALD, Helmsdale. (*non-oral*)  
 LUNDIE, Rev. D. (E.C.), Tongue. (*non-oral*)  
 MACARA, Dr J. F., Durness. (*non-oral*)  
 MACASKILL, HUGH, Crofter, Fanagmore.  
 MACASKILL, Rev. J. (U.F.C.), Kinlochbervie.  
 MACDONALD, HUGH, Strathalladale, Chairman of the Parish Council of Farr.  
 MACKENZIE, KENNETH, Crofter, Stoer. (*non-oral*)  
 MACKAY, DAVID, Crofter, Lairg. (*non-oral*)  
 MACKAY, DONALD, Crofter, Strathnaver. (*non-oral*)

MACKAY, EVANDER, Crofter, Strathnaver.  
MACIVER, NEIL, Teacher, Stoer. (*non-oral*)  
MACLENNAN, Dr F. P., Lochinver.  
MACLEOD, REV. MALCOLM (U.F.O.), Melness. (*non-oral*)  
MACLEOD, MURDO, Free Presbyterian Missionary, Stoer.  
MACRAE, Dr Ji D., Bonar.  
MENNIE, JAMES. Chemist, Golspie.  
MOWAT, Dr A., Lairg.  
MUNRO, J. G., Crofter, Rogart. (*non-oral*)  
MUNRO, THOMAS, Crofter, Bettyhill. (*non-oral*)  
PIRIE, ANGUS, Weaver, Rogart.  
SILVER, Dr J., Farr. (*non-oral*)  
SIMPSON, Dr J. BERTIE, Golspie

**Source: Highlands and Islands Medical Service Committee. Report to the lords commissioners of His Majesty's Treasury. Volume I. 1912-13, Cd.6559, pp.111-118.**

## APPENDIX 6

### HIGHLANDS AND ISLANDS (MEDICAL SERVICE) GRANT ACT, 1913.

AN ACT TO PROVIDE A SPECIAL GRANT FOR THE PURPOSE OF IMPROVING MEDICAL SERVICE IN THE HIGHLANDS AND ISLANDS OF SCOTLAND, AND FOR OTHER PURPOSES CONNECTED THEREWITH (15TH AUGUST 1913).

Be it enacted by the King's Most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows: -

1. (1) In every financial year there shall be paid out of money to be provided by Parliament the sum of forty-two thousand pounds, which shall be called the Highlands and Islands (Medical Service) Grant, and shall be paid to a separate fund to be called the Highlands and Islands (Medical Service) Fund.

(2) The Highlands and Islands (Medical Service) Fund shall, subject to such regulations as may be made by the Treasury with respect to accounts, audit, and accumulation of the fund, be administered and applied by the Highlands and Islands (Medical Service) Board (hereinafter called the Board) appointed under this Act, in accordance with a scheme or schemes to be prepared by the and approved by the Secretary for Scotland with the consent of the Treasury, for the purpose of improving medical service, including nursing, in the Highlands and Islands of Scotland, and otherwise providing and improving means for the prevention, treatment, and alleviation of illness and suffering therein.

2. (1) For the purposes of this Act, it shall be lawful for His Majesty, by warrant under high sign manual, to appoint a Board consisting of not less than five and not more than nine members, one of whom shall be a woman, to be called the Highlands and Islands (Medical Service) Board. One of the members of the Board shall be appointed by His Majesty to be chairman of the Board.

(2) The Board may act by any four, or, if the total number of the Board is six or less, by any three of their number, and notwithstanding any vacancy in their number.

(3) The Secretary for Scotland may appoint a secretary to the Board, and the Board may, with the consent of the Treasury as to numbers, appoint and employ such officers and servants for the purposes of this Act as they think necessary, and may remove any officer or servant so appointed or employed, and there shall be paid to the secretary, officers, and servants such salaries or remuneration as the Board, or in the case of the secretary the Secretary for Scotland, with the consent of the Treasury, may determine.

(4) The salary of the secretary and the salaries or remuneration of the officers and servants, and any expenses incurred by the Board in the execution of their duties under this Act, to such amount as may be sanctioned by the Treasury, shall be defrayed out of moneys provided by Parliament.

(5) The Board shall make an annual report of their proceedings to the Secretary for Scotland, and that report shall forthwith be laid before Parliament.

3. (1) Provision shall be made by scheme under this Act for the conditions under which any money from the Highlands and Islands (Medical Service) Fund placed at the disposal of local authorities, insurance committees, district nursing associations, or other bodies or persons or any joint committee of local authorities or insurance committees or of local authorities and insurance

committees is to be applied by them, and as respects any money from that Fund which is to be applied by the Board, as to the purposes for which it is to be so applied.

(2) Where under any such scheme any money is to be applied by the Board for the purpose of building houses for medical practitioners or nurses, or for the purpose of building hospitals, or for any other purposes for which land may be required, the Board, if the money is to be applied to them, shall, if the scheme so provides, have the like powers for those purposes with respect to the acquisition, holding, and disposal of land as authorities under the Public Health (Scotland) Act, 1897, have for the purposes of that Act, and that Act shall be construed accordingly.

(3) Where under any such scheme any money is to be applied by a local authority for any purpose, that authority shall have all such powers for the purpose as the scheme may provide, and, if the scheme so provides, any powers vested in a local authority of acquiring land, or erecting buildings, or borrowing on the security of any rate for any purpose, shall be extended so as to include the purposes of the scheme, and any Act conferring any such power shall be construed accordingly.

(4) Any scheme under this Act may be revoked or varied by a scheme prepared and approved in like manner as the original scheme.

(5) The provisions of section fifteen of the Public Health (Scotland) Act, 1897, with respect to the removal of a medical officer by or with the sanction of the Local Government Board for Scotland shall, within the areas specified in the schedule to this Act, extend to any medical practitioner appointed by a parish council for the purpose of any duties of that council.

4. The provisions of section fifteen of the Local Government (Scotland) Act, 1908, with respect to the transfer of hospitals, sanatoria, of houses of reception, and land connected or used therewith, shall apply with respect to transfers to the Board as they apply with respect as they apply with respect to transfers to a local authority, with the substitution of the Secretary for Scotland for the Local Government Board for Scotland, and shall be extended so as to include power to transfer to the Board any building or land for any purposes for which money is to be applied by the Board.

5. In this Act:-

The expression "Highlands and Islands" means the areas specified in the Schedule to this Act.

The expression "local authority" means county councils and any authority under the Public Health (Scotland) Act, 1897, and parish councils, school boards, and secondary education committees, and includes any joint committee of local authorities and insurance committees shall have power to appoint joint committees for the purpose of this Act.

6. (1) This Act may be cited as the Highlands and Islands (Medical Service) Grant Act, 1913.

(2) The powers of the Board under this Act shall, unless continued by Parliament, cease on the thirty-first day of December nineteen hundred and seventeen, and, in the event of their so ceasing, His Majesty may, by Order in Council, provide for the administration and application of the Highlands and Islands (Medical Service) Fund, and for the exercise and performance of any powers and duties under this Act or under any Scheme made under this Act by such other persons, bodies or local authorities as His Majesty thinks fit to substitute for the Board.

**Source: Highlands and Islands (Medical Service) Grant Act, 1913, rekeyed.**



## APPENDIX 7a

### Highlands and Islands Medical Service Contract (page 1)

#### HIGHLANDS AND ISLANDS MEDICAL SERVICE) GRANT ACT, 1913.

AGREEMENT between the Highlands and Islands Medical Service Board (hereinafter called "the Board") of the one part and Dr. James Murray of Inverness (hereinafter called "the practitioner") of the other part, whereby it is agreed as follows:-

1. For the purposes of this Agreement the area of the practitioner's ordinary practice shall be the parish of Inverness (excluding the Burgh of Inverness) and such other districts adjoining the aforesaid area as where, for the time being, insured persons on the practitioner's list may be resident.

2. The fees chargeable by the practitioner for medical attendance and treatment provided under this Agreement shall not exceed those specified below, and no addition shall be made to such fees in respect of the distance from the practitioner's residence to the place of residence of the patient attended, viz:-

To the families and dependants of the insured persons on the practitioner's list, to the uninsured persons of the crofter and cottar classes and their families and others in like circumstances to whom the practitioner has been accustomed to give medical attendance, a fee not exceeding five shillings for the first visit and two shillings and sixpence for each subsequent visit in the same illness. In midwifery cases the fee shall not exceed twenty shillings to patients of the classes referred to and no additional charge shall be made for travelling expenses incurred in attending such cases.

In the event of any dispute as to whether any patient resident within the aforesaid area as specified in Article 2 hereof comes within the scope of the arrangements for medical attendance and treatment at the foregoing rates, the matter shall be decided by the Board, and the practitioner shall give attendance in accordance with the decision of the Board. But nothing herein contained shall infer any liability on the Board for said fees.

3. The practitioner shall keep a classified register, to be supplied by the Board, of all persons attended by him under this Agreement, including paupers, old age pensioners, and insured persons, showing in each case the number of visits paid, the distance of the patient from the practitioner's residence and the fees collected in respect of attendance, which register shall be open to the inspection of any accredited Officer of the Board.

4. Notwithstanding the date hereof this Agreement shall be deemed to have commenced as on the first day of January 1915, and shall continue in force until the thirty-first day of December 1915, and from year to year thereafter, provided always that either party may at any time terminate this Agreement on giving three months' previous notice in writing to the other party.

5. The Board shall, provided the practitioner has implemented his part of this Agreement to their satisfaction, pay to the practitioner a sum at the rate of One pound from first January to thirty-first December, 1915, and at the rate of Five pounds a year thereafter, which sum shall be payable in each year by two instalments, the first, amounting to 45% of the sum for the year, being payable as at the thirtieth day of June, and the second, representing the balance of 55%, being payable at thirty-first December, or as soon after said respective dates as is practicable; and in the event of this Agreement being terminated prior to 31st December in any year, the payment for that year so far as then remaining due shall be made as soon after such termination as is practicable. In the event of the practitioner not having implemented his part of this Agreement to the satisfaction of the Board, the Board may withhold and cancel the right to such portion, or even the whole of the sum payable to the practitioner, as they think proper.

6. Any notice to be given by, or on behalf of, the Board shall be sufficient if signed by any member of the Board, or the Secretary thereof, and a certificate or letter signed by any member of the Board, or the Secretary thereof, shall be final and conclusive evidence as to the decision of the Board as to any sum due under this Agreement or as to the satisfaction or non-satisfaction of the Board and the extent to which the Board have resolved to withhold or cancel the right to any payment under this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as follows:-

Signed for and on behalf of the Highlands and Islands Medical Service Board  
 at.....on the.....day of.....  
 One Thousand Nine hundred and.....in presence of -  
 Name.....  
 Address.....Member.  
 Designation.....Member.  
 Name.....Secretary.  
 Address.....  
 Designation.....

Signed /

Source: By kind permission of Dr Wallace, former GP, Shiskin, Arran.

## APPENDIX 7b

### Highlands and Islands Medical Service Contract (page 2)

Signed by the above-named Dr. James Murray at.....  
.....day of.....One Thousand Nine Hundred and.....  
of =

.....  
.....  
.....  
.....  
.....  
.....  
.....

.....6d. Stamp.....

Qualifications.....

Source: By kind permission of Dr Wallace, former GP, Shiskin, Arran.

## APPENDIX 8

### **PUBLIC NOTICE OF ARRANGEMENTS BETWEEN THE HIGHLANDS AND ISLANDS MEDICAL SERVICE BOARD AND MEDICAL PRACTITIONERS.**

1. The HIGHLANDS AND ISLANDS MEDICAL SERVICE BOARD hereby give notice to all whom it may concern that they have entered into Agreements with the Practitioners named in the annexed Schedules whereby medical attendance is made available to certain classes of the community in the districts and on the terms and conditions set forth below:

2. PERSONS ELIGIBLE TO RECEIVE MEDICAL ATTENDANCE AT MODIFIED FEES:

The families and dependants of the insured persons, uninsured persons of the cottar and crofter classes and their families and dependants, and others in like circumstances to whom the payment of the Practitioner's ordinary fee for medical attendance would be an undue burden.

3. FEES CHARGEABLE TO THE PERSONS REFERRED TO IN SECTION 2 HEREOF:

A fee not exceeding 5s. for the first visit, and 2s. 6d. for each subsequent visit in the same illness. Midwifery fees (including fees for any subsequent visits that may be necessary), £1.

THE FEES WILL BE THE SAME WHATEVER BE THE DISTANCE OF THE PATIENT FROM THE DOCTOR'S PLACE OF RESIDENCE.

An additional and moderate charge will be made for medicines supplied by Practitioners. Where medicines are not dispensed by the Practitioners, patients must themselves pay the chemists' charges.

4. The treatment to be given by Practitioners in respect of the fees specified in Section 3 hereof is treatment of a kind which can be properly undertaken by a general Practitioner.

5. In the event of any dispute as to whether any patient comes within the scope of the arrangements between the Board and the Practitioners, the matter shall be decided by the Board. The decision of the Board in such cases will be based on the circumstances of the patient in each case, and such evidence as the Board may require in regard thereto must be forthcoming in all cases where an appeal is made to the Board.

6. Persons desiring to participate in the benefits of the Board's scheme must be prepared to comply with all such reasonable requirements of the Practitioner as will enable him to make the best arrangements for his patients.

Messages requesting the attendance of the Practitioner should, if possible, reach him before the hour on which he ordinarily begins to visit patients, and, if sent later in the day, they should invariably state whether a visit on the following day is regarded as sufficient.

In cases where the Practitioner is accustomed to make fixed visits on certain specified days to particular localities, all calls for his services, except in urgent cases, should be reserved for these days.

Where duly qualified district nurses are available, special calls for the services of the doctor, outside ordinary visiting hours, to patients living at a distance should be made through the nurse wherever practicable.

7. In cases where two or more Practitioners practise in the same area, the patient may select the Practitioner whose services he desires to have, but urgent calls for medical assistance should, as a rule, be sent to the nearest available Practitioner.

8. It should be clearly understood that Practitioners called to cases outside the area in which they have undertaken to give attendance under arrangements with the Board, as shown in the annexed Schedule, may charge their ordinary visiting fees.

9. The Agreements between the Board and Practitioners do not interfere in any way with any private arrangements which may be in existence between Practitioners and their patients, whereby the latter receive attendance under a system of annual payments per individual or per family.

10. If it is proved to the satisfaction of the Board that the privilege of a medical service at modified fees is misused in any district or by any individual, the Board reserve the right to withdraw the service from any such district or individual. In such cases that Practitioner's ordinary fee will be payable.

L McQuibban, Secretary

**HIGHLANDS AND ISLANDS MEDICAL SERVICE BOARD,  
4A ST ANDREW SQUARE  
EDINBURGH, 1ST JANUARY 1917.**

**Source: Source: By kind permission of Dr Wallace, former GP, Shiskin, Arran. (Rekeyed.)**

## APPENDIX 9

**Statement Showing the Amount and Distribution of the Total Work in 1917 of Practitioners for 114 Practices Working Under Arrangements with the Board, and the Like Information For 116 Practices in 1918.**

		<b>1. Travelling</b>								
	<b>Year</b>	<b>Argyll</b>	<b>Caithness</b>	<b>Iny Ness</b>	<b>Ross &amp; Crom</b>	<b>Sutherland</b>	<b>Orkney</b>	<b>Shetland</b>	<b>Perth</b>	<b>Total</b>
<b>Population in ..</b>	1911	70,902	32,010	65,056	77,364	20,179	11,130	27,911	14,492	319,044
<b>Number of Practices</b>	1917	29	6	29	18	9	5	8	10	114
	1918	27	6	31	19	9	7	8	9	116
<b>TOTAL NO OF MILES TRAVELLED</b>		<b>Miles</b>	<b>Miles</b>	<b>Miles</b>	<b>Miles</b>	<b>Miles</b>	<b>Miles</b>	<b>Miles</b>	<b>Miles</b>	<b>Miles</b>
a) By motor car, motor cycle, horse and trap, and boat.	1917	134,515	54,393	135,955	105,487	54,708	11,895	43,791	48,720	589,464
	1918	130,000	62,068	175,753	121,086	66,923	13,648	36,993	42,134	648,605
b) By ordinary cycle, by train and on foot.	1917	29,419	10,877	34,100	24,001	9,205	5,348	3,977	4,081	121,008
	1918	26,486	11,403	36,962	19,533	10,553	6,841	7,527	2,623	121,928
<b>Total Travelling</b>	1917	163,934	65,270	170,055	129,488	63,913	17,243	47,768	52,801	710,472
	1918	156,486	73,471	212,715	140,619	77,476	20,489	44,520	44,757	770,533
<b>Average per Practice</b>	1917	5,653	10,878	5,864	7,194,	7,101	3,448	5,971	5,280	6,232
	1918	5,796	12,245	6,862	7,401	8,608	2,927	5,565	4,973	6,642
<b>Increase(+) or Decrease(-) in 1918</b>		+2.5	+12.6	+17.0	+2.9	+21	-15	-6.8	+5.8	+6.6
<b>PERCENTAGE OF TOTAL TRAVELLING REFERABLE TO:</b>										
<b>Poor Law Patients</b>	1917	5.4	4.7	8.2	6.9	13.6	3.6	9.9	7.2	
	1918	3.5	3.3	6.4	5.6	13.0	2.6	8.7	5.8	
<b>Insured Patients</b>	1917	25.3	22.6	22.4	20.0	30.0	14.5	19.9	22.5	
	1918	23.8	25.1	22.3	22.3	29.8	10.7	21.4	23.3	
<b>Patients Treated under arrgmts. with the Board</b>	1917	33.3	29.0	32.6	48.3	33.0	43.9	34.5	38.7	
	1918	37.8	36.5	37.7	54.0	39.9	49.7	39.9	43.3	
<b>Patients treated under arrgmts. with other Public Bodies</b>	1917	6.7	0.2	5.0	2.9	7.4	1.1	2.3	4.2	
	1918	7.6	0.3	5.4	2.9	4.3	1.2	1.2	4.1	
<b>'Club' Patients</b>	1917	1.9	22.4	13.9	0.1	-	22.6	-	6.4	
	1918	2.1	17.7	13.7	0.1	-	33.5	-	6.8	
<b>Private Patients</b>	1917	27.4	21.0	17.9	21.8	16.0	14.3	33.4	21.0	
	1918	25.2	17.1	14.5	15.1	13.0	2.3	28.8	16.7	

Statement Showing the Amount and Distribution of the Total Work in 1917 of Practitioners for 114 Practices Working Under Arrangements with the Board, and the Like Information For 116 Practices in 1918.

2. Visits

	Year	Argyll		Caithness		Inverness		Ross & Cromarty		Sutherland		Orkney		Shetland		Perth		Total	
No and % of Visits to:		Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
<b>Poor L. Patients</b>	1917	2,812	<b>4.4</b>	935	<b>4.2</b>	44,322	<b>9.8</b>	3,473	<b>7.5</b>	1,498	<b>9.4</b>	224	<b>4.7</b>	876	<b>6.1</b>	1,102	<b>7.2</b>	15,242	<b>6.7</b>
	1918	2,007	<b>2.8</b>	1,265	<b>4.0</b>	4,566	<b>7.3</b>	3,672	<b>6.1</b>	1,606	<b>7.7</b>	196	<b>3.0</b>	560	<b>5.0</b>	7,789	<b>5.1</b>	14,661	<b>5.3</b>
<b>Insured Patients</b>	1917	14,141	<b>22.2</b>	5,162	<b>23.5</b>	9,887	<b>22.4</b>	9,236	<b>20.0</b>	3,568	<b>22.4</b>	661	<b>13.8</b>	3,446	<b>24.0</b>	3,158	<b>20.8</b>	49,259	<b>21.8</b>
	1918	15,996	<b>22.8</b>	8,018	<b>25.4</b>	15,711	<b>25.0</b>	12,481	<b>20.9</b>	5,002	<b>24.1</b>	693	<b>10.6</b>	2,681	<b>24.0</b>	3,565	<b>22.9</b>	64,147	<b>23.0</b>
<b>Patients treated under - Board</b>	1917	12,110	<b>19.0</b>	3,500	<b>15.9</b>	10,021	<b>22.7</b>	13,959	<b>30.3</b>	3,023	<b>18.9</b>	1,486	<b>31.0</b>	9,060	<b>63.0</b>	3,477	<b>22.9</b>	56,636	<b>25.0</b>
<b>under - other</b>	1918	14,308	<b>20.4</b>	6,497	<b>20.6</b>	17,191	<b>27.4</b>	23,492	<b>39.3</b>	5,950	<b>28.6</b>	2,154	<b>32.8</b>	7,460	<b>66.7</b>	4,192	<b>27.0</b>	81,244	<b>29.2</b>
<b>Public Bodies</b>	1917	9,126	<b>14.4</b>	74	<b>.3</b>	2,273	<b>5.1</b>	4,076	<b>8.8</b>	2,610	<b>16.3</b>	123	<b>2.6</b>	37	<b>.3</b>	371	<b>2.4</b>	18,690	<b>8.3</b>
<b>Club Patients</b>	1918	11,776	<b>16.8</b>	131	<b>.4</b>	2,966	<b>4.7</b>	5,267	<b>8.8</b>	1,867	<b>9.0</b>	79	<b>1.2</b>	51	<b>.4</b>	232	<b>1.5</b>	22,369	<b>8.0</b>
	1917	5,616	<b>8.8</b>	3,928	<b>17.8</b>	7,183	<b>16.3</b>	532	<b>1.2</b>	4	-	1,351	<b>28.2</b>	5	-	2	-	18,621	<b>8.2</b>
	1918	5,902	<b>8.4</b>	4,617	<b>14.7</b>	9,584	<b>15.3</b>	457	<b>.8</b>	6	-	3,127	<b>47.7</b>	-	-	26	<b>.2</b>	23,719	<b>8.5</b>
<b>Private Patients</b>	1917	19,871	<b>31.2</b>	8,443	<b>38.3</b>	10,479	<b>23.7</b>	14,880	<b>32.2</b>	5,267	<b>33</b>	941	<b>19.7</b>	955	<b>6.6</b>	7,113	<b>46.7</b>	67,949	<b>30.0</b>
	1918	20,253	<b>28.8</b>	11,021	<b>34.9</b>	12,747	<b>20.3</b>	14,438	<b>24.1</b>	6,371	<b>30.6</b>	311	<b>4.7</b>	436	<b>3.9</b>	6,721	<b>43.3</b>	72,298	<b>26.0</b>
<b>Total No of Visits</b>	1917	63,676	-	22,042	-	44,165	-	46,156	-	15,970	-	4,786	-	14,379	-	15,223	-	226,397	-
	1918	70,242	-	31,549	-	62,765	-	59,807	-	20,802	-	6,560	-	11,188	-	15,525	-	278,438	-
<b>Average per Practice *</b>	1917	63,676	-	3,674	-	1,523	-	2,564	-	1,774	-	957	-	1,797	-	1,522	-	1,986	-
	1918	70,242	-	5,258	-	2,025	-	3,148	-	2,311	-	937	-	1,398	-	1,725	-	2,400	-
<b>Increase (+) or decrease (-) in 1918</b>		+18.5	-	+43.1	-	+32.9	-	+22.8	-	+30.3	-	-2.1	-	-22.2	-	+13.3	-	+20.8	-

Inverness - Excludes Inverness Burgh.

Perth - Highland District only.

\* Figures for visits do not include consultations at doctor's consulting Rooms.

**Source: Fifth Report of the Highlands and Islands Medical Service Board, Cmd.169, 1919, pp.10-11.**

## **APPENDIX 10**

### **CONSULTATIVE COUNCIL ON HIGHLANDS AND ISLANDS PERSONNEL 1920**

- Duchess of Atholl, Member of Highlands and Islands Medical Service Committee, President of the Perthshire Federation of District Nursing Associations
- John Birnie, ex-Provost of Inverness
- William Durran, ex-Provost of Thurso
- Rev. Wm Fotheringham, Vice Chairman of Zetland County Council Insurance Committee, late Convenor of the County
- Lady Susan Gilmour, late member of the Highlands and Islands (Medical Service) Board
- Miss Bello Jobson, Secretary of Scottish Fish Workers' Friendly Society
- Mrs Helen Kerr, Member of the Royal Commission on Housing
- The Maclachlan of Maclachlan, Convenor of the County of Argyll
- Miss Sybil M. MacPhail, Honorary Secretary to the Ladies Highland Association
- Dr A.C. Miller, Chairman of the Highlands and Islands Sub-Committee of the British Medical Association (Scottish Committee)
- Wm. J. Munro, Clerk to Easter Ross District Committee
- Dr Donald Murray, late Medical Officer of Health for Lewis
- James B. Simpson, Vice-President of the Sutherland Nursing Association and Secretary to the County Local Medical Committee
- Miss Margaret White, Superintendent of the Queen Victoria Jubilee Institute for Nurses (Scottish Branch)

**Source: TNA T161/1304, S2433/2, Report of the Consultative Council on the Highlands and Islands, 1927.**

# APPENDIX 11a

## REGISTRATION CARD, QUEEN'S NURSE

NAME ADDRESS *44 B. Newmarket, Loughale,*

OTHER QUALIFICATIONS

RELIGION *W. B. Church* MOTORIST *Yes* LANGUAGES *Speaks Gaelic*

SCHOOL *Game-Reaper* SINGLE, MARRIED OR WIDOW *Single*

CYCLIST *Yes* PREV. EMPLOYMENT *At home*

TESTIMONIALS: "This Maciver was a thoroughly capable, reliable nurse, most conscientious and devoted to duty. A rather reserved, hesitating manner told against her." - E. C. R. Philip, Matron, Northern Infirmary.

REMARKS: A capable conscientious nurse, who has given excellent service and maintained a high standard, well received by the community.  
J. G. Smith, Superintendent, Scottish Branch W. B. D. N. 10<sup>th</sup> July 1951.

DEFERRED ANNUITY *S. L. A. 1951.*

QUEEN'S INSTITUTE OF DISTRICT NURSING RONEDEX PATENT Nos. 298481 & 40-103 RONEDEX CARD No. ED.C14879.

APPOINTMENTS

APPOINTMENT	DISTRICT	ENTERED	LEFT	CAUSE OF LEAVING	APPOINTMENT	DISTRICT	ENTERED	LEFT	CAUSE OF LEAVING
G. N.	Harris, Lewis	22.11.20	20.10.21	Leave of absence from duties	G. N.	Loughale (ret)	11.2.36	11.2.38	Health off duty - 11/2/38
	Do (ret)	3.2.22	1.6.23	Health		Do (ret)	14.3.38	31.1.51	Refused
	Do (ret)	1.9.23	7.3.24	Change				15.7.51	Refused
	Strathkerron	7.3.24	1.10.24	Change and duties				10/11/74	
	Monimail	10.11.24	6.10.25	Leave of absence					
	Clydebank	2.4.28	6.7.28	Health					
	Quintin	14.9.28	30.6.31	Change					
	Lanark	1.3.32	11.3.33	Temp.					
		11.3.33	31.1.33	Off duty					
	Paisley	31.1.33	1.3.33	Temp.					

Source: Queen Victoria Jubilee Institute, Registration card, 1920.



# APPENDIX 11b

## WORK CARD, QUEEN'S NURSE

INSPECTION REPORTS			
7.6.22	"Good average Nurse, very quiet." - M. Boyd.	7.2.41	"Very Capable and conscientious" - A. J. Weir.
23.3.25	"Conscientious, hard-working Nurse" - C. Carnegie.	20.9.41	"Capable and conscientious" - A. J. Weir.
7.6.29	"Very good, agreeable" - F. S. Beattie.	26.11.42	"Capable and conscientious" - A. J. Weir.
23.10.29	"Careful + methodical worker" - J. E. Dumas.	8.12.42	"Capable and conscientious" - A. J. Weir.
2.12.30	"A very good, hard-working Nurse" - F. S. Beattie.	21.3.43	"Capable and conscientious" - A. J. Weir.
2.9.33	"Conscientious + reliable" - D. Cameron.	6.10.43	"Capable + conscientious" - A. J. Weir.
7.2.34	"Reliable Nurse" - S. R. Angus.	6.3.44	"Capable + conscientious" - A. J. Weir.
11.8.34	"Good steady Nurse" - D. Cameron.	5.9.44	"Capable + conscientious" - A. J. Weir.
2.6.35	"Capable, conscientious Nurse" - A. T. Weir.	3.2.45	"Capable + conscientious" - A. J. Weir.
5.6.36	"Capable + hard-working" - A. T. Weir.	24.8.45	"Capable + conscientious" - A. J. Weir.
1.6.37	"Very good worker" - A. T. Weir.	19.3.46	"Capable + conscientious" - A. J. Weir.
6.6.38	"Good steady Nurse" - D. Cameron.	13.1.47	"Capable + conscientious" - A. J. Weir.
10.5.39	"Capable Nurse" - A. J. Weir.	19.1.48	"Capable + very conscientious" - A. J. Weir.
7.5.40	"Capable Worker" - A. T. Weir.	21.3.49	"Good capable Nurse, much appreciated" - J. R. Hargy.
5.6.40	"Nurse does her work, but works hard" - D. Cameron.		

  

ROLL No. 6126	EXAM. RESULT 37.	BADGE No.	LONG SERVICE BADGE 30/6/47
HOSPITAL TRAINING The Northern Infirmary, Inverness, 1.3.16 - 1.5.19.			
OTHER HOSPITAL AND NURSING EXPERIENCE Claremont Nursing Home, Glasgow. Staff Nurse, 18.9.19 - Nov 1919.			
NIDWIFERY TRAINING Glasgow, June 12, 1920 - Nov 1920			
DISTRICT TRAINING Glasgow, 8.1.20 - 16.5.20.			
REPORT OF SUPERINTENDENT FOR SCOTLAND: "Miss Maciver has a gentle, quiet manner and is pleasant with the patients. She has been thoroughly well trained in District routine, and is a credit to her Training Home. She ought to prove a valuable Queen's Nurse." - E. J. Colburn, Inspector, 12.6.20.			
REPORT OF SUPERINTENDENT OF TRAINING HOME: "A good painstaking Nurse, very interested in			

Source: Queen Victoria Jubilee Institute, Work card, 1920.

## APPENDIX 12

### LIST OF NURSING ASSOCIATIONS IN OUTER ISLES SUBSIDISED BY BOARD, 1916

Nursing Association	Name of Nurse and Experience	Qualifications
<b><u>LEWIS</u></b>		
Bernera Nursing Assn	Margaret MacDonald	Fully-trained - 3 yrs. Rochdale (Dearnley Infirmary); Fever training Maternity training
Lochs Lurebost N.A.	Jessie Ann Macrae	6 mths Glasgow Maternity Hospital
Point Nursing Assn	Mrs Margaret A MacGregor	Queen's Nurse.
	Christina Macleod	Plaistow-trained.
West Uig Nursing Assn	McCloy	Govan-trained
<b><u>HARRIS</u></b>		
Harris Nursing & Medical Assn	Mrs Amelia Cunningham	2 yrs Bedford Infirmary 6 mths Bootle Infectious Hospital; Private and District Nursing, Bradford (Total of above - 5yrs) Private Nursing in Ross-shire, 1912-15: Midwifery training, 4 months, 1915, 'Hospice', Edinburgh
	Catherine McLean	Recommended by Dr Fletcher, Portree.
	-MacLean	"Never came across her equal" - Dr Victor Ross.
	Mrs Sarah McLeod	1 yr general training Edinburgh Infirmary and Dingwall Hospital; Midwifery training (certificate).
In direct employment of Board	Violet Kennedy	Q.N.
<b><u>SOUTH UIST</u></b>		
Barra Nursing Assn	Mrs John Campbell	Govan Trained. C.M.B.
Benbecula Nursing Assn	Margaret M Watherston	Q.N.

Daliburgh Nursing Assn	Kathleen A O'Donnell	Q.N.
Eriskay Nursing Assn	Christina MacKinnon	3 yrs Bute Daliburgh; 1 yr Govan Training Home; C.M.B. Royal Naval Hospital, Mount Stuart, Rothesay, ? - October, 1916.
Iochdar Nursing Assn	Flora R MacDonald	Q.N.
Middle District N.A.	Annie J Smith	6 mths Royal Maternity Hospital, Glasgow; 3 yrs Medical Surgery, Airdrie, 4 yrs Roxburgh Nursing Association.

### **NORTH UIST**

Berneray (Lochmaddy) Nursing Association	Margaret Campbell	Govan-trained.
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### **SKYE**

Arnisort & Snizort Nursing Assn	-	Hitherto Q.N. New Nurse in June - ? Q.N.
Kilmuir (East Bide) Nursing Assn	Mary MacDonald	3 mths Chalmers Hospital, Edinburgh; 2 yrs Royal Samaritan Hospital, Glasgow; 4 mths Royal Maternity Hospital, Glasgow; C.M.B.
Kilmuir Nursing Assn	-	Hitherto Q.N. New Nurse recently - ? Q.N.
Sleat Nursing Assn	Campbell	Govan-trained; C.M.B.
Strath Nursing Assn	Eliza Maclean	Govan-trained:- 3 yrs Govan Training Home; 3 mths Glasgow Maternity Hospital; C.M.B.; 5 yrs District Nurse.
Uig Nursing Assn	Kate O'Brien	3 yrs The Home, Earlston, Berwickshire; 4 yrs Galashield Cottage Hospital; 3 mths Royal Maternity Hospital, Dundee.
Waternish Nursing Assn	Helen Macleod	Fairly well trained - gave satisfaction in Fair Isle, Shetland, where she was District Nurse previous to going to Skye.

**Source: NRS, HH65/9, General File, Highlands and Islands Medical Service Fund, 1916.**

## APPENDIX 13

### AN ACCOUNT OF A QUEEN'S NURSE TAKING UP DUTY IN THE OUTER HEBRIDES IN MIDWINTER, C1920.

"I arrived with nothing but what I travelled in, - the purser could not let me have my boxes. That same evening I had a message to call on a sick woman the following morning, and was on my way when I received a wire from the fishing boat. After making enquiries, I was told I had better go home till the crew was collected, and someone would come for me. I thought they would never come. It was almost noon when they were ready, and by that time my boxes were at the pier here, and I opened one and got a clean apron.

"The rain was falling heavy, and the wind was high. I was rowed out in a small boat, and lifted like a child into the fishing boat, and told to sit on the nets and not to be afraid.

"I was very wet when we arrived about 1 pm. The Doctor came to meet me, took me home, gave me a hot drink, and wrapped me in his muffler and overcoat, before taking me to the patient's house.

"The boat waited for me, and one of the crew brought me home. The night was dark, and the roads here are very narrow, rough, and steep. The man carried my bag, and took me by the hand, and kept telling me I would not fall, which I am sure I would have done, had he not taken such care of me.

"I have a patient in another island, just over the Sound. Her husband and son come over with a boat for me, and bring me back again. The boat is rowed across in about eight minutes, when the water is calm, but it takes some time to get to the beach, the moor is soft, and there are so many rocks to climb. I have got instructions not to leave the house till someone comes for me, which is usually 10 am I go there first. The man walks in front, sideways, holding me by the hand, and telling me where to put my feet next, and by the time we get to the rocks, the old man comes, and takes my other hand and leads me down and helps me to the boat. I believe the rule is that whoever needs the Nurse on the Island, shall see her safe home, and they do. I could not get to the boat if they did not guide me as they do.

"The Doctor does not come over to this Island unless I send for him. If any one wishes the Doctor, I visit them, and either wire or send the fishing boat and give the skipper a note with particulars.

"I was passing a house the other day and was invited in (I am nearly pulled into all houses here). I noticed the baby had a very sore head, and in fear and trembling I suggested a starch poultice would clean it, if the mother would allow me. She can't speak English very well, but said she would be very jolly if I would. I made one and applied it, showed her how to make it, and advised her how often to renew it, and I am really surprised to see how well she is doing it. Her house is of two apartments; both have mud floors. The kitchen fire is in the middle of the floor, and what smoke does not rest in the house, goes through a hole in the roof. There are four beds in the room - no fire. Very few houses have beds in the kitchen, but they all sleep in the room, quite regardless of sex or age. It is in a house such as this where I expect my first confinement, and I could not get any information regarding expected time or anything else. The woman does not understand me.

"There is not a cupboard of any description in this house, my cloaks and coats hang on my wall. There is not even a drawer where I could put a thing. I could have wept when I saw my room. There were two beds in it, and my landlady wanted to sleep in the room with me. She did with the last Nurse, but I explained as nicely as I could, that I had not been used with company and would take ill with it. I had one bed removed since, as well as a few boxes, vases of paper flowers and other rubbish, and I try to clean another corner every day. The landlady did not want to cook for me, and I really did not care. She is not clean, but it is not easy to cook with only two enameled pans and a frying pan. That is the stock here. However, there is little to cook - mutton boiled, fried, or stewed, or herrings, and eggs.

"I make my dinner in the evening, and so far I have had plenty of time. I have sent home for stores and asked for a couple of pots, and some other cooking utensils; milk is very scarce, so I have to manage without puddings, but acting on your advice I bought some dried fruit. There are no vegetables on the island except onions and wet potatoes. Porridge is out of the question, as there is no milk. The Secretary says if I try to put up here for a little, he thinks I will be able to get a nice room in a house which is being built.

"Although the women do not work much in their houses, they spin, and weave, knit, bake, pack herring, carry water and peats, which must be hard work, as the roads are so steep and rough. The men fish, mind the sheep, gather stones to build, and do what repairs they can, and cut peats when weather permits. They all seem very happy and all try to be very kind to me, but I cannot get used to living like this all at once. To-day is the first fine day since I came, and after doing my work, I went a long walk, then I saw a woman waving and shouting in Gaelic, and went to see what was wrong, and her husband explained that she had watched for me ever since I came, and could not speak to me, but wanted me to know I was welcome. Poor souls, they have so little interest! There is nothing to be seen but water and hills, but to-day it was very beautiful, the snow fell heavily last night and lay on the hills. It did look pretty!

"I do not feel the cold nearly so much as I did in the South, though everybody says this is the worst winter they have had for years. We get a certain amount of shelter from the hills. On Christmas Day I was very miserable - never had a day like it. There was nothing in the place but salt herring, which I had for dinner, and baked sago and apples for pudding. A nice Christmas dinner! You would laugh if you saw me bake a pudding. There is no oven, no ashpan-the ashes just fall. I gather them together and spread them flat, lay my pie-dish on that, with the lid of a biscuit tin on top to keep the ashes out. I poke the fire and let some red peat cinders lie on my tin lid, and if the pudding does not quick enough, I put a live peat on either side, and have always managed. I toast cheese in the same way. On New Year's Day I was called out at 3 am, returned at 6, and lay long in bed-got up and baked some pancakes and unearthed some of my treasures from my box, and laid my table. The mail had come and some nice eatables, so I invited my two nearest neighbours and my landlady to tea. If I felt I could not sit down to another lonely meal. They were delighted, at first they rubbed their hands and looked, but after they began, they lost their shyness.

"I have been very busy this last week, but I am happier now. I have to go to the extreme ends of the Island; one was twice daily, but only once to-night; the patient on the other Island still needs me, so that keeps me very busy. The old man comes alone for me now, and lets me take an oar. I don't know how we managed over to-day. The boat rolled from side to side, and I kept repeating the sailor's prayer, and was thankful to get on land again.

"The people were very anxious for me to remain over night, but I said I would try again if the old man would take me. He said he would not take me in a small boat, but if he could collect a crew

he would put out a fishing boat, which he did. Five men rowed me over, and it was hard work. They are all so kind, it makes the very best that is in me come to the top. They trust me so, I feel it would be a breach of faith were I to show fear while in the boat with them.

"The people seem more accustomed to me now, and though many women come to me for advice and say they have 'no English', and bring their interpreter, often a man, sometimes just a friend, seldom the husband, I always ask to be left alone. I find they can say enough for me to understand them, if once they begin, but are shy to talk English in front of anyone else in case they laugh at them. I found that out one night when I brought an old woman home. I go half way. I have a few Gaelic phrases, and though I cannot speak them like a native, I do, and they can laugh if they like.

"The life here is certainly very different to what I have been used to. It is a blessing I was brought up in the country. I am very happy at my work and when outside, but at night when I sit down, if I thought very much about my surroundings I'd be home-sick".

**Source: The Story of the Queen's Nurses in Scotland, Edinburgh, c1920. Queen Victoria's Jubilee Institute for Nurses.**

# Appendix 14: Nurses employed in the Highlands and Islands in 1917

County/ District	Jubilee	Fully trained, Not Jubilee	Partially trained	Training not known	Midwives	Handy women	General and Maternity	Total
<b>Orkney</b>								
Kirkwall	0	0	0	0	0	5	1	<b>6</b>
Mainland	1	0	0	0	1	0	0	<b>2</b>
N. Isles	0	1	0	0	0	0	1	<b>2</b>
S. Ronaldsay	0	0	0	0	0	0	0	<b>0</b>
Walls	0	0	0	0	0	0	0	<b>0</b>
<b>Caithness</b>								
Wick	2	0	0	0	6	0	0	<b>8</b>
Thurso	1	0	0	0	2	0	0	<b>3</b>
County	1	2	0	2	3	0	0	<b>8</b>
<b>Sutherland</b>								
County	2	1	12	0	2	0	0	<b>17</b>
<b>Ross &amp; Cromarty</b>								
Stornoway	1	0	0	0	4	1	0	<b>6</b>
Black Isle	0	0	0	2	0	1	0	<b>3</b>
Easter Ross	0	0	0	3	5	0	0	<b>8</b>
Mid Ross	0	1	6	2	9	1	1	<b>20</b>
South-Western	0	0	0	0	1	3	1	<b>5</b>
Western	0	0	0	2	2	6	0	<b>10</b>
Lewis	7	0	6	4	3	0	0	<b>20</b>

<b>County/ District</b>	<b>Jubilee</b>	<b>Fully trained, Not Jubilee</b>	<b>Partially trained</b>	<b>Training not known</b>	<b>Midwives</b>	<b>Handy women</b>	<b>General and Maternity</b>	<b>Total</b>
<b>Inverness</b>								
Inverness (Burgh)	2	0	0	0	53	21	15	<b>91</b>
Inverness (Cty District)	1	0	0	0	3	1	0	<b>5</b>
Aird	0	0	0	0	5	0	0	<b>5</b>
Badenoch	0	2	0	4	2	9	0	<b>17</b>
Lochaber	4	0	2	1	2	4	0	<b>13</b>
Harris	5	0	0	0	0	0	0	<b>5</b>
N. Uist	1	0	1	0	0	0	0	<b>2</b>
S. Uist	6	0	0	0	0	8	0	<b>14</b>
Skye	0	2	0	7	0	0	0	<b>9</b>
<b>Perth</b>								
Highland	0	1	8	0	3	10	0	<b>22</b>
<b>Argyll</b>								
Oban	1	0	0	0	2	0	0	<b>3</b>
Campbeltown	1	0	0	0	1	8	1	<b>11</b>
Dunoon	1	0	0	0	1	5	0	<b>7</b>
Ardnamurchan	4	0	0	0	0	0	0	<b>4</b>
Lorn	10	0	0	0	1	0	0	<b>11</b>
Mid-Argyll	7	0	0	0	0	6	0	<b>13</b>
Cowal	4	0	0	0	1	5	0	<b>10</b>
Kintyre	3	0	0	0	0	1	0	<b>4</b>
Mull	7	0	0	0	1	0	0	<b>8</b>
Islay	3	0	0	0	0	4	0	<b>7</b>
<b>Total</b>	<b>75</b>	<b>10</b>	<b>35</b>	<b>27</b>	<b>113</b>	<b>99</b>	<b>20</b>	<b>379</b>

**Source: Atholl MSS 7/4, National Health Insurance Commission (Scotland) 1917. Report on Hospital and Nursing Services in Scotland.**



## PHOTOGRAPHS



Plate 1: Shetland nurse on bike, 1930s. © Shetland Museum Photographic Archive.



Plate 2: Shetland nurse on motorbike, c.1930s. © Shetland Museum Photographic Archive.



Plate 3: The Dewar Committee, 1912. © John Dewar & Sons.



Plate 4: John A. Dewar, Former Lord Provost of Perth and Chairman of the Highlands and Islands Medical Services Committee. © Perth & Kinross Council Archive.



Plate 5: Murdoch Beaton, Secretary, Dewar Enquiry. By kind permission of Iain Beaton, Skye, grandson of Murdoch Beaton.



Plate 6: Highlands and Islands Medical Services Committee tour, 1912. © John Dewar & Sons.



Plate 7: Highlands and Islands Medical Services Committee tour, 1912. © John Dewar & Sons.



Plate 8: Doctor H.P. Taylor and car, Yell, Shetland. ©Shetland Museum Photographic Archive.





Plate 9: Opening of Gilbert Bain Hospital, Lerwick, 1902. ©Shetland Museum Photographic Archive.



Plate 10: Isolation hospital, Lerwick. ©Shetland Museum Photographic Archive.



Plate 11: Man giving directions to Nurse Margaret Davidson, Foula. ©Shetland Museum Photographic Archive.



Plate 12: Mary Breckinridge, founder of the Kentucky Frontier Nursing Association. Courtesy of Frontier Nursing Service Archives.

©Photo



Plate 13: Kentucky Frontier Nurses on horseback. ©Photo Courtesy of Frontier Nursing Service Archives.



Plate 14, District Nurse with car, c.1930. ©Shetland Museum Photographic Archive.